Care Quality Commission

Tracs Limited

Highbridge Court

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 16 and 17 July 2015 and was unannounced. We received further information of concern about the safety of people and revisited the home on 27 August 2015 to check people were safe.

Highbridge Court is a care home providing accommodation for up to nine people with mental health needs. At the time of our inspection, five people were living in the home.

The service had a registered manager at the time of our initial inspection in July. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. When we visited in August, we found the registered manager had left Highbridge Court. The nominated individual told us, "We're close to appointing a new manager and our Operations Manager is working in the home for two days each week. They will

Summary of findings

continue to provide support for some time to come." This meant support was provided by another manager and the Operations Manager two days each week until a new manager was appointed.

Although there were systems to assess the quality of the service provided in the home, we found these were not effective. The systems had not ensured that people were protected against some key risks, such as inappropriate or unsafe care and support, and had failed to identify areas for improvement.

Risks to people were poorly managed. People were not fully protected from the risk of harm. When risks had been identified there was either limited or no information how to support people whilst reducing the risk.Where a serious incident had occurred risk assessments were not reviewed and no measures put in place to prevent a further incident occurring.

Although staff were knowledgeable about recognising abuse they did not always respond appropriately to allegations of abuse. People were not involved in their care planning. Care plans did not always contain specific information about the support required to meet people's individual needs.

No protocols were in place to guide staff when people refused medicines. The impact of people refusing medicines had not been risk assessed or escalated and staff did not seek medical advice when people refused medicines.

Recruitment procedures did not appear to be properly followed to ensure people with the right experience and character were employed by the service. Following the inspection we received information that confirmed to missing references were held at their head office.

People were not supported by staff with appropriate training for their specific mental health conditions. When in depth training relating to mental health conditions, such as personality disorder and self-harm had been offered to the team, there had been a 'low uptake' from staff. Staff told us they were well supported by the registered manager of the home at the inspection in July but the manager has since left the service.

Care records showed people who lack capacity to make decision had not had their rights protected. This was because staff lacked the understanding of the appropriate legislation to protect people in these circumstances.

People had been involved in planning the menus used in the home. They had been asked which meals on the menu they enjoyed and if there were any meals that they did not like. People were able to do their own food shopping.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering the action we will be taking and will produce a report in the future.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff did not recognise or respond appropriately to abuse. Some staff were unaware of the relevant reporting procedures for reporting to a local authority.

Risks to people were poorly managed. Where risk assessments had been completed they did not include relevant information for staff to support people safely.

There was no guidance for staff how to manage medicines safely when people refused medicines.

There were enough staff available to meet people's needs.

Is the service effective?

Requires improvement

The service was not effective.

People were not supported with effectively trained staff that helped them understand people's specific mental health conditions.

People's rights were not protected because the principles of the Mental Capacity Act 2005 had not been used.

Care assessments did not consider the full range of people's needs.

People did not benefit from the organisation seeking support or input from other relevant teams and services.

People were encouraged to be as independent as possible with their meals and were given choices.

Is the service caring?

Requires improvement

The service was not fully caring.

People's privacy and dignity was not always fully respected.

People were relaxed around staff and people engaged staff in conversations and laughter.

Is the service responsive?

Requires improvement

The service was not responsive.

Peoples care plans did not always contain specific information about the support required to meet their individual needs.

People were enabled to complain if they were dissatisfied with the service.

People's views were sought to ensure they were satisfied with the service.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Although the registered manager was approachable and staff were confident to speak with them, since August there was no registered manager in the home, however support was provided by another experienced manager two days each week.

People were not protected by the provider's quality assurance systems. Although there were systems to assess the quality of the service provided in the home, we found these were not effective. The provider had not ensured that people were protected against some key risks such as inappropriate or unsafe care and support.

Highbridge Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We checked to see whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 July and was unannounced. The inspection team comprised of two inspectors. The home is a new purpose built facility which was registered with the Care Quality Commission in December 2014; this was the first inspection of the home.

This scheduled inspection was brought forward due to concerns raised about the service. Before our inspection we reviewed information we held about the home, including notifications about important events which staff had sent to us. During the inspection, the registered manager provided us with a range of documents, such as copies of internal audits, action plans and quality audits, which gave us key information about the service and any planned improvements.

We spoke with four people who used the service. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for four people. We spoke with the registered manager, area manager and three care staff. We looked at four staff files. We looked at records about the management of the service. We also spoke with one health care professional.

We re-visited Highbridge Court on 27 August 2015 due to concerns about people's safety. We spoke with the nominated individual, a care worker and an agency worker. We also looked at four care plans, safeguarding records and the accident/incident file. Following our return visit on 27 August, we telephoned five members of staff to ask about changes to the support for people since our visit 16 and 17 July 2015.

Inadequate

Is the service safe?

Our findings

People's risks were not well managed which meant they were not fully protected from the risk of harm. Although people told us they felt safe and said things like, "Up to now I feel safe, yes" and "Yes, I'm safe", this is not what we found.

Where risks had been identified there was either limited or no information on how to reduce the risk. For example, one person had been identified as being at a high risk of behaviours which could be dangerous to other people. Whilst the risk had been identified there was limited information on how to reduce the risk. However there was a note in their assessment record that room searches were necessary. The registered manager told us, "We do room checks every day when the person is in there, though they are not behaviour specific checks. We haven't put anything in place for checking but everyone is aware of the person's background."

Another person had risks identified when they accessed the community, but there was no guidance for staff on how to reduce the associated risk with this activity. This meant there was a risk for those in the community and also the person was not being protected from the consequences of displaying complex behaviours in the community. For another person where behaviours around members of the opposite sex were identified as a risk, there was no information on what action staff should take to reduce this risk and support this person. This left the person vulnerable and the community and staff at risk.

Another person had been identified as being at high risk whilst cooking as they could become aggressive. The person had access to their own kitchen in their flat but there was no written information to guide staff on how to recognise and reduce the risk, or how to manage this person's behaviour. We raised this with the management during our inspection in July and were assured these would be reviewed. When we visited Highbridge Court on 27 August 2015, the risk assessment was dated 16 April 2015 with no review date. The risk assessment advised staff to support the person where necessary. Whilst the person's history identified challenging behaviours when staff intervened there remained no information on how to manage this and reduce any risks. We asked staff what they knew about triggers which might affect people's behaviour. Staff told us, "We don't know about triggers, I think it's just our own observations. We've been made aware of some people and some situations, but we don't know how a trigger may affect people at different times." This meant staff were not always provided with guidance on triggers which may cause people to exhibit challenging behaviours. It also meant people were not supported to manage their complex behaviours.

A risk assessment for another person who used an exercise bike had not been reviewed despite it stating it was to be reviewed monthly. Another person had a specific behaviour identified in their care plan and they had a history of displaying this whilst out in the community. There had been two recent incidents of this nature. We discussed this with the clinical lead and they told us, "They should have called me sooner. I don't think staff realise the intense need to contact the care team and seek my support if required." We asked them what the impact on people using the service was as they had not been involved sooner, for example, where the person was facing criminal charges. They told us, "If (the person) had the medicines review and support needed they might not be in the situation (the person) is in now." We reviewed this person's care file when we visited Highbridge Court on 27 August 2015. Staff were required to document what the person was wearing every day so that if they were in the community, they would be identifiable; however this record had not been maintained.

Where incidents had occurred involving individual people living in the home, no action had been taken to reduce the risk of reoccurrence. For example, where a serious incident with one person had taken place their risk assessment had not been reviewed with measures on how to reduce the risk of it happening again. A member of staff told us they were aware of the incident and felt it could happen again. We spoke with the deputy manager who confirmed the risk assessment had not been reviewed and updated following the incident. The deputy manager told us "I reported it to CQC and safeguarding but I did not follow up to seek advice from relevant health professionals." The senior clinical lead said, "I would have hoped to be informed about this but I wasn't. They didn't ask for phone advice" and "Staff should follow up on my suggestions, but they don't always."

We read the incident file when we visited on August. Staff had told us of four incidents for one person but the incident file only recorded two of these. This meant incidents were not being accurately identified or reported,

which meant people may not have received the support they needed. This also meant the registered manager was not able to take action to prevent these incidents re-occurring.

An incident the registered manager notified to CQC was not prevented because one person's refusal to take medicines had not been escalated to appropriate clinical staff. We asked the senior clinical member of the organisation what was the impact of this not being escalated. They said, "I should have been called sooner and informed of the incident when it occurred, the risk assessment should have been reviewed, they (the home) are reluctant to call me and I don't know why." They also told us "When a person's mental health deteriorates, when I am made aware I will come in." We spoke with the registered manager who told us they agreed a protocol should have been in place. They said, "I have been busy lately with another incident."

We discussed the issues of risk with the registered manager who acknowledged the risk assessments did not contain enough information and should be reviewed. They also acknowledged this was their responsibility, commenting, "I'm not making excuses. I should be updating them and putting a lot more information in."

We also spoke with a senior clinical member of the provider organisation about their involvement in the home in relation to supporting them to manage risk. They told us they were involved in developing guidelines and protocols with the team commenting "I come to Highbridge Court when requested by the management, I've been here four or five times since it opened and can give guidance on the phone." We were aware that nine incidents occurred whilst people were in the community and people's risk assessments had not been reviewed or updated following these incidents. People in the community were at risk because Highbridge Court had not managed these risks. The senior clinical manager told us following these incidents they would be spending more time "Targeting the home." A senior manager said, "We've got to record things. From a company point of view we know we've got a lot of work to do."

During our second visit in August, the nominated individual told us they had been working closely with mental health teams to review people's needs.

When we revisited the home in August, there were two members of staff on duty, a care worker and an agency worker. There were three people who used the service on the premises at the time. The agency worker told us it was their second shift in the home but there were no staff available for them to shadow that week. They said, "I had a really good read of the care plans last week, they've got the information we need." We asked them to tell us what they knew about people, particularly regarding any risk assessments in place. They were able to identify some of the risks posed by people, but did not know some important information needed to protect the public or other people in the home. They told us, "I'm not aware of any other risks." This meant the agency care worker and other people may be at risk because they were not fully informed about specific challenging behaviours and risks people at Highbridge Court posed.

When people refused their medicines, the protocols in place were not followed. One person regularly refused their medicines. Staff told us this was because the medicines impacted negatively on how the person was feeling. Although the refusals had been appropriately recorded, the impact of this had not been risk assessed or escalated to an appropriate senior manager or to the person's GP. This meant the issues the person was experiencing and their reason for refusing medicines was not reviewed or discussed with appropriate professionals. When we raised this during our inspection, this person's records were reviewed and advice sought immediately. Staff were also asked to read and sign to acknowledge they were aware of the process to be followed.

One aspect of medicines management had changed during our second visit in August. Staff told us they were now documenting and seeking advice when people were refusing their medicines. This meant people were less likely to have adverse effects as a result of refusing their medicines. We saw guidance for staff for medicines which were taken as needed had been put in place. The guidance said two staff needed to agree the specific medicine was appropriate before this was given. However, on the day of our visit, there was only one member of staff able to administer medicines on site. The nominated individual told us staff were able to access an on-call number for advice and guidance at any time, and this could be used to discuss the use of a specific type of medication if necessary.

One person we spoke with told us they were not able to have pain relief when they needed it. We looked at their

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care plan and saw staff recorded the person told them they were in pain. However staff recorded they told the person there was nothing available to give them and they should "Drink more water." This meant the person may have been in pain and the risk of this had not been considered.

Staff had not been made aware of an adverse effect if certain fruit juices were taken with one person's medicine. The registered manager acknowledged this and said they knew about the restrictions but had not put it in the care plan and had not made staff aware. When we revisited the home in august, we asked if staff had been made aware of the need for this person to avoid cranberry juice. One member of staff told us, "I didn't know [the person] couldn't have cranberry juice. They could go out and buy it if they wanted to." This meant any risks associated with this were not properly managed because staff had not been made aware.

One person was subject to a legal process should they wish to stay overnight away from the home. The information in the person's care plan did not make this process clear to staff. This meant there was a risk staff would not follow the correct process which may have placed the person at risk.

The business continuity file gave high level generic information which did not guide staff how to deal with emergencies in the home. For example, it gave information about fire or explosions in neighbouring buildings, gas leaks and other emergencies which were aimed at office staff and did not provide guidance for Highbridge Court staff. There was no guidance available should alternative accommodation be required. The policy referred to outdated health incidents and gave clinical guidelines such as cleaning, but said nothing about staff cover or restricting visitors. The emergency grab file contained information for three people only and the information was out of date. This meant in an emergency situation staff would not have the information they needed to manage the situation safely. We raised this with the registered manager who assured us they would review the protocol.

When we revisited the home in August, we asked the member of staff in charge if there had been any changes to the business continuity plan; they told us they weren't aware of this plan. We asked what they would do in the event of an emergency. They told us, "Evacuate, to the fire point at the front of the building I think. If it was blocked then off the top of my head I think we would go to the back garden, but I'm not quite sure." This was in line with the home's evacuation procedure. We also saw the emergency grab file had been updated and information was available for people and staff.

People were not protected from risks associated with Legionella disease because staff told us taps were not flushed in empty rooms. We spoke with the registered manager about this who acknowledged this should be done. We saw conflicting information in one person's care plan which noted they had a medical condition which was contagious. The care plan noted the person had been advised to stay out of the kitchen, dining room and laundry. We did not see any records regarding treatment or monitoring of this condition. This person's daily records showed the person was carrying out their laundry duties regularly 'with minimal staff support.' We asked the registered manager about this and they told us they thought the condition had healed, but were unable to confirm this. This meant Highbridge Court may have exposed other people to the risk of infection. They assured us this would be followed up and records amended to show the current situation. After the inspection, the provider explained this was an old document which was removed from the care file.

When we re visited the home in August, we asked a member of staff if they had been provided with an update regarding a person's contagious skin condition. They told us, "I didn't know anything about it." This meant staff had not been provided with any information and may have been exposed to unnecessary risk.

The poor risk management was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training in safeguarding vulnerable adults. Although staff were knowledgeable in recognising signs of potential abuse, some staff were unaware of the relevant procedures for reporting to the local authority. One member of staff told us, "We have an out of hour's number and could phone the area operations manager. If nothing was done I'd wait a significant time (weeks) and go above them". This meant potential abuse may not be reported in a timely and appropriate way.

We identified a safeguarding incident had occurred during our inspection. This had not been recognised as a safeguarding matter at the time it occurred. We discussed

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this with staff, who realised they should have reported it. Staff said, "I can't believe I missed this, I know it was a safeguarding." We brought this to the registered manager's attention and the response they gave us about how they would manage it was not in line with local authority safeguarding procedures. The deputy manager reported the incident during our inspection. This meant people who may have been abused were not being protected.

We asked to see safeguarding records where notifications had been made to the local authority safeguarding team. We were told safeguarding referrals were recorded in people's care plans but these were not in the care plans. We asked if there was a system to prompt staff to follow up safeguarding referrals and were told, "We never follow them up." This meant the registered manager was unable to identify whether a safeguarding referral had been properly dealt with. However, after the inspection the provider made us aware that safeguarding records were held centrally. This meant people were at risk of suffering abuse because the manager did not follow the organisations safeguarding protocols.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a recruitment policy which included all staff completing Disclosure and Barring Service (DBS) checks and obtaining two references. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people. Staff told us they were not able to work with people until the appropriate pre-employment checks had been undertaken. We looked at four staff files; two of these had unexplained gaps in employment history and one file only contained one reference. However all staff had a completed Disclosure and Barring Service check. We discussed the lack of references and unexplained gaps in employment history with the registered manager and showed them the files; they assured us they would follow these up. Following the inspection we received information that confirmed the missing references were due to these being held at their head office.

The registered manager told us staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased if required. The registered manager informed us extra staff could be sourced from another home or from staff on call to provide one to one support for people if necessary.

People told us, "If you're short of staff people are under pressure. They're not often short of staff, only when they're on annual leave and they have to search to cover the difference" and "I can go out when I want as long as there's a member of staff available to go with me. There are times when I would like to go out and can't." Other comments included, "There's 24 hour support here. Sometimes I might have to wait for a bit while staff are with others" and "Sometimes in the morning there's only one member of staff here for a few hours." Staff told us they felt there were enough staff on duty. Staff said, "Staffing levels are ok" and "We've used bank and agency staff to make the numbers up."

Medicines were securely stored. We saw medicines administration records had been completed, which gave details of the medicines people had been supported to take. Medicines inventory checks had been completed monthly and no errors had been recorded. Staff told us they were aware of the side effects of medicines and had guidance how to deal with these. Staff said, "We've got access to information and know about the side effects" and "It's a robust system. We have competency observations and the manager signs us off."

Requires improvement

Is the service effective?

Our findings

People were not always supported with staff who were suitably trained. People told us, "Staff have had training but they don't use it" and "I don't think staff are trained well enough." People with specific mental health needs were being looked in the home but the staff training did not cover all areas that would help staff understand and meet people's needs. The clinical lead told us more in depth training related to mental health conditions such as personality disorder and self-harm had been offered to the team, however there had been a "Low uptake from Highbridge Court. The registered manager told us this was because they couldn't release staff from their duties. They went on to tell us they had arranged for a week's training in August 2015 to cover conditions in more depth. The registered manager acknowledged staff had not received the necessary training and told us, "Training has been offered but staff were unable to attend due to covering the home. I can't release all staff.

Training was delivered by the registered manager and external agencies. The registered manager told us, "The training is very basic and we are arranging more in depth training. I can't comment on how effective the training is." The senior manager told us mental health conditions were 'touched on' during this training. One staff member told us they would "Benefit from more in-depth training around specific conditions." The registered manager told us two of the staff members had previous mental health experience and all the others were "Pretty new." We asked them how they ensured the team were trained and competent to meet the needs of the people living at the home. They told us this would be through planned training dates, they said staff had received basic one day mental health training and more was being arranged. A senior clinical lead said, "It's obvious to me we've got a lot to do here. We've identified some training we need to do. The registered manager should have been calling me in sooner."

Staff told us they received a range of training when they joined the service including a 12 week induction covering mandatory training and other topics relating to their role. One staff member described the training as "Informative." Another staff member said, "I've had it all. My Studio 3 refresher training is due soon." The Studio 3 training referred to covered caring for people who may exhibit behaviours of concern. In addition to the mandatory training three members of staff were completing training linked to the Qualification and Credit Framework (QCF) in health and social care to further increase their skills and knowledge in how to support people with their care needs.

The system used to record the training that staff had completed and to identify when training needed to be repeated was not up to date. Training records did not record when each member of staff had last completed a training course to provide a way of knowing when updates were due. However each staff member also had a file that recorded the training they had completed and certificates they had been awarded but information in the two systems did not agree. This meant the registered manager could not easily identify if staff had completed all the required training or needed to repeat a training course to keep up to date with current best practice.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of the Mental Capacity Act (MCA) 2005. This is legislation to protect people who may not be able to make decisions for themselves. Staff said, "Everyone here is on an informal basis, no-one is sectioned" and "We can't tell them what they can or can't do, everything is their choice." We discussed the MCA with the registered manager and a senior member of the organisation. Four of the people living at Highbridge Court had their medicines locked away and staff administered their medicines. This had been identified as a restriction in one person's care plan; however there was no assessment of their capacity to agree to this practice or best interest decisions involving appropriate professionals or families. This meant Highbridge Court may be placing unnecessary restrictions on people and people's human rights were not being protected.

People's care records showed that the principles of the Mental Capacity Act 2005 Code of Practice had not been used because there were no capacity assessments for assessing an individual's ability to make a particular decision. For example, one person who often refused medicines had not had their mental capacity assessed or a meeting arranged to decide if this was appropriate and in their best interests. Care plans did not contain completed capacity assessments or consider where people may have fluctuating capacity. The clinical lead said, "There have not

Requires improvement

Is the service effective?

been any specific mental capacity assessments yet because we haven't got that far yet" and "I'm not sure one person had the capacity to agree to something they signed up to."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. At the time of the inspection the registered manager told us no-one was deprived of their liberty. Staff told us, "I haven't had any DOLs training, I've only heard about it" and "I know about best interest meetings because I had them where I worked previously." We asked the registered manager at what point, following any incidents, did they intervene to keep people safe. The registered manager said, "People are on informal placements so we are unable to restrict people. There are no DoLS in place. We encourage people to come back at a reasonable time." This meant there were no systems in place to assess whether people had varying degrees of capacity and consequently no processes for keeping people safe.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received regular supervision from their manager and told us they were happy with the process. Staff said, "I feel supported" and "We have a nine month probation and have monthly supervisions." These processes gave staff an opportunity to discuss their performance.

During our inspection we saw that people were provided with enough to eat and drink. People said, "I have my own cooker and fridge in my room. We cook five days and staff cook at weekends. We have a roast dinner every Sunday evening" and "Staff eat with us." Staff said, "We ask people what kind of food they want on the menu" and "There's always an option of something else." People had been involved in planning the menus used in the home. They had been asked which meals on the menu they enjoyed and if there were any meals that they did not like. People were able to do their own food shopping.

People told us, "They take care of all of my health needs" and "It's my choice not to see the dentist. I see the same doctor every time though." We saw one person's care records which stated they were to meet with their care co-ordinator and social work team; however, we did not see these meetings had taken place.

Requires improvement

Is the service caring?

Our findings

Two people told us they were not involved in their care planning. One said "I haven't seen my care plan, I'm not involved in it, they do all of that" and "No, I don't know about it. I don't understand it." Each person had a care plan that was personal to them and six monthly care reviews were held with people and their relatives. The registered manager told us they "Didn't think staff involved people in their care plans" and "Care plans are our bug bear. We're a new team and staff haven't got it yet." This meant people's views were not taken into consideration when their care plans were written.

People told us staff did not always respect their privacy. One person told us "Staff don't always knock. They've got a key and come in. I don't like this" and "Most staff ask before entering my room." Another person told us staff had entered their room on two occasions without knocking. This had been raised with the registered manager and the person was satisfied with the outcome. Staff were able to give us examples of how they protected people's privacy and dignity. They told us they ensured any support given to people was done privately. Staff said, "I pride myself on being client focussed" and "I always prioritise people." One staff member told us "We don't talk about people in front of others, and I always knock on doors before entering." We saw staff knocked on people's doors before entering.

Staff interactions with people demonstrated people were relaxed around them. People engaged with staff in light-hearted conversations.

Some people were happy with the staff and they got on well with them. however one person said, "Night staff tell me to get back into bed, I'm not allowed up at night. They don't respect my choices. When I get up they tell me to go back to bed. It's like a prison here." This was brought to the manager's attention who made a safeguarding referral. Other comments people made included, "Staff are just there. They don't do anything and I can't chat with them." Other people said, "Staff are wonderful", "This place is the crème de la crème" and "I'm very happy here indeed." Other comments included, "Staff are good" and "I had a buffet and birthday cake on my birthday." Another person told us, "Staff treat me with respect. I don't give them the opportunity to have a go at me for no reason" and "Staff listen to me; they take it in their stride."

People were able to have regular one to one meetings with their key workers. This gave them the opportunity to voice their opinions and give feedback. People told us, "We don't have the residents meetings all together, they see everyone separately." We asked staff how they knew what was important to people. Staff said, "We ask them and have a meeting with them" and "Everything should be recorded in their care plans."

One person told us they had asked a member of staff about advocacy but said, "They didn't know anything about it." The registered manager confirmed this person had not been offered advocacy and said they would arrange it. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

Requires improvement

Is the service responsive?

Our findings

Care plans did not always contain specific information about the support required to meet people's individual needs. For example, where a person had a specific mental health condition there was no detailed information in their care plan for staff to follow and there were no guidelines around how to meet the needs of the person in relation to their condition. Care plans contained minimal information about people's likes, dislikes and preferred routines.

One person's care plan contained information from a previous service. This had not been reviewed or updated since the person moved to Highbridge Court. We asked the registered manager what re-assessments had been completed since the person moved to the home. They acknowledged this should have been reviewed and updated either by himself or the deputy and commented, "Things have been overlooked with everything that has been going on."

People's care records contained detailed information relating to people's backgrounds from other healthcare providers. However, this information had not been detailed in their current care plan. We saw that each person's needs had been assessed before they were offered accommodation at the home. The information in the needs assessments had not been fully included in the home's risk assessments and care plans. For example, one person had been identified as displaying challenging behaviour towards staff and other people. There were no details of this is their current care plan.

This was a breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated knowledge about the people living in the home by describing what was important to them. For example, they described how one person liked to play pool and do yoga in the garden. They went on to describe the important relationship the person had with their family member.

People told us they were not aware of the formal complaint procedure, but that they knew the registered manager and felt comfortable speaking with them if they had any concerns. People told us, "I don't need to make a complaint, if things are not right I will talk to the manager", "I've no complaints" and "If there's anything out of line I can say things to people, but I've not had to say anything." We saw the service's complaints process was included in information given to people when they started receiving care. At the time of our inspection the service had received one complaint. This had been investigated and fully resolved.

Meetings were held monthly with people for them to raise any issues, ideas or concerns with staff. Where items had been raised we saw these were actioned and the minutes of the meeting were updated. For example, one person had requested a fan for their flat and this had been purchased. One person told us they felt staff listened to them commenting "I let staff know what I need and they listen and act." They went on to say, "Staff ask me if I'm happy and if I've settled in alright."

Satisfaction questionnaires were not available to obtain feedback from people who use the service at the time of our inspection, but the manager explained they would be distributed later in the year. The manager informed us this was due to the service only being open for seven months.

Inadequate

Is the service well-led?

Our findings

Although there were systems to assess the quality of the service provided in the home, we found these were not effective and placed people at risk of harm. The systems had not ensured that people were protected against inappropriate or unsafe care and support. The public were also at risk as a consequence.

The provider's quality team carried out a 'Key Performance Audit' of the home. The team completed audits of the systems and practice to assess the quality of the service on 29 April 2015 and 31 May 2015. These had not identified the issues and causes for concern we found throughout our inspection. In particular they had not identified the poor risk management of the home. In fact the audit gave the home a maximum positive score for care plans and risk assessments. Comments about these in their audit were that 'all risk assessments were within review timescales'.

They had not identified the lack of contact with appropriate professionals, such as the GP when people refused medicines. They had not identified people's rights were not being protected through the appropriate use of the Mental Capacity Act 2005. They had not identified that staff were not always trained to meet people's needs. In fact the audit scored the staff training and supervision as high. Therefore no action plan was produced and no areas for improvement were identified.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst staff said they would be confident to speak to the registered manager if they had any concerns about another staff member, they were inconsistent about how to report safeguarding issues. They told us that they had no concerns about the practice or behaviour of any other staff members. Staff told us they were well supported by the registered manager of the home. Staff meetings were held which were used to keep staff up to date with relevant information. One staff member told us the meetings were used to "Make suggestions for improvement, we are able to raise any concerns or ideas and things change as a result." They went on to give us an example of when staff suggested some outside furniture would benefit people living in the home to give them more space. They told us they were listened to and the furniture had been purchased.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of significant events. This meant we could check that appropriate action had been taken.

We spoke to the registered manager and regional manager about the concerns we found at the home during our visit. The registered manager said, "I feel isolated. I think they forget I'm new." Throughout the discussion they acknowledged our findings and accepted urgent improvements were required. Following our inspection, the nominated individual has sent us regular updates regarding improvements made.

When we visited in August, we found the registered manager had left Highbridge Court. The nominated individual told us, "We're close to appointing a new manager and our Operations Manager is working in the home for two days each week. They will continue to provide support for some time to come." This meant support was provided by another manager and the Operations Manager two days each week until a new manager was appointed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks of unsafe care and treatment because risks to the health and safety of service users of receiving care or treatment were not always assessed. Regulation 12 (2) (a). Highbridge Court did not do all that was reasonably practicable to mitigate any such risks. Regulation 12 (2) (b). Medicines were not managed safely. Regulation 12 (2) (g). Systems were not in place to assess the risk of, prevent, detect and control the spread of infections. Regulation 12 (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not provided with the necessary training to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person, but if Part 4 or 4A of the 1983 Mental Health Act applies to a service user, the registered person must act in accordance with the provisions of that Act. The provider did not act in accordance with the Mental Capacity Act (2005). Regulation 11 (3) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not operated effectively to monitor and improve the quality and safety of the service. Regulation 17 (2) (a) Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Regulation 17 (2) (c)