Tamhealth Limited

Highfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 02 August 2017 and was unannounced.

Highfield Care Home provides nursing and personal care for up to 49 older people, some of whom were living with dementia. At the time of the inspection there were 47 people living in the home.

The registered manager recently left the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider had recently employed a manager who was not yet registered with CQC.

People and their relatives felt that the home and the care delivered met their needs. However we found that the care people received had not always promoted their safety regarding pressure care management and nutrition.

Care plans were not up to date and did not provide staff with sufficient guidance to meet people`s needs safely and effectively. People`s likes, dislikes and preferences regarding their care was not always captured in their care plan or considered by staff when delivering the care and support people needed. Care records were not always legible and easy to read.

People told us they felt staff protected their dignity and privacy, however we observed that some of the staff`s actions had a negative impact on people`s dignity.

Where potential risks to people's health, well-being or safety had been identified, these were assessed however not regularly reviewed to take account of people's changing needs and circumstances. Food and fluid monitoring charts were not completed effectively and for people who were losing significant amount of weight it was not clear what the staff were doing to promote good food and fluid intake.

People told us their call bells were answered in a timely way. The provider used a dependency tool to inform their staffing levels. However we observed that there were a high numbers of people with complex needs who may have benefitted from more time spent with them, however staff were not able to do this.

Safe and effective recruitment practices were followed to ensure that staff working at the home were of good character and suitable for the roles they performed.

People received their medicines safely and had access to healthcare professionals such as GP's, dentists, opticians and chiropodists when required.

We found that staff obtained people's consent before providing the day-to-day care they required however

mental capacity assessments were not always carried out to establish if people had capacity to understand and take decisions regarding the care and support they received.

Staff were caring and attentive to people's needs and interacted with people in a warm and respectful manner. People were given choices in such areas as food, activities and where they wanted to spend their time.

There were a variety of activities available in the home however a high number of people were cared for in their bedrooms and more one to one activities were needed to meet people`s social needs. The provider was in the process to recruit an additional activity staff to meet people`s needs.

People were encouraged and supported to raise concerns and the manager closely monitored and sought feedback about the services provided to identify areas for improvement.

The manager and the provider completed a range of quality audits to monitor the quality of the service provided however we found that these had not been effective in identifying the issues we found at this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe, however the care people received was not always promoting their safety.

People told us their call bells were answered promptly, however we observed staff working in a task orientated way and not being able to spend time with people.

Staff were knowledgeable about the risks of abuse and told us they would not hesitate to report their concerns internally and externally to local safeguarding authorities.

Recruitment procedures were robust and ensured there were suitable staff working at the home.

Medicines were administered safely by appropriately trained staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments were not always carried out to establish if people had capacity to understand and take decisions regarding the care and support they received.

People told us they were offered sufficient food and drinks.

Staff received regular supervision and training and they felt supported to carry out their roles effectively.

People had access to health care professionals when there was a need for it.

Is the service caring?

Requires Improvement

The service was not always caring.

Care was provided in a way that promoted people's dignity and respected their privacy, however staff had not considered that

some of their actions had a negative impact on people`s dignity.

People were looked after in a kind and compassionate way by staff who knew them well and understood their individual needs.

Some people told us they were involved in the planning and reviewing of their care; however some people were not aware they had a care plan or a key worker they could discuss the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received care and support which was not always personalised to take account of their likes, dislikes and preferences regarding their care.

People were supported to pursue their hobbies and interest however more one to one activities were needed for people cared for in their rooms.

People and their relatives felt confident to raise concerns and had confidence these would be dealt with.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems used to review and manage risks and drive improvement within the home were not always effective in identifying the issues we found.

People`s care records were not up to date and some were not legible.

People, their relatives and staff were very positive about how the home operated and told us that they felt the manager was approachable, visible and responded to their feedback positively.

Staff told us they understood their roles and responsibilities and were supported by senior colleagues.

Highfield Care Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and carried out on 02 August 2017 by two inspectors and a specialist advisor. The specialist advisor had experience of working as a nurse and provided specialist advice on the nursing care being provided at Highfield Care Home. They had a specialism of elderly care, dementia and pressure care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with nine people who lived at the home, four relatives, five staff members, two nurses, the activity coordinator, the chef, the deputy manager and the provider`s regional support manager. We also received feedback from social and health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

We looked at care plans relating to eight people and two staff files in addition to records relating to the management of the service.

We carried out observations throughout the day and used the short observation framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex needs.

Requires Improvement

Is the service safe?

Our findings

People living at Highfield Care Home told us they felt safe. One person told us, "I feel very safe here." Another person said, "I do feels safe here, they [staff] are very good." One relative said, "My [relative] is safe here."

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. This included in areas such as medicines, pressure care, mobility, health and welfare.

We found that at times the care and support people received did not promote their health and welfare. We looked at how staff managed risks relating to the care and support for people who lived with diabetes. We found that one person`s blood sugar levels were taken twice daily and they received insulin to control their blood sugars. The blood sugar levels for this person were consistently higher than is recommended by health professionals. Staff told us that this person was not compliant with their advice about their diet however this was not documented in their care plans. There were no detailed plans to instruct staff when to ask for specialist advice regarding this person`s diabetes. We saw that this person was last seen by the diabetic nurse in March 2017. This meant that the person was at risk of developing health complications that are associated as being harmful to have continually high blood sugar levels that if left over a period of months may permanently affect the eyes, nerves, kidneys and blood vessels. The nursing staff should have requested a visit from the specialist Diabetic Nurse for a review of this person`s insulin dose.

We also looked how staff were managing the needs of the people who used a catheter. A catheter is used when people have continence problems. For example a person who had a catheter had experienced repeated urinary tract infections (UTI). Staff had contacted their GP and the person had been prescribed regular antibiotics to prevent these infections reoccurring. This person`s care plan which was created by nurses at the home instructed staff to change the bag which was attached to the catheter to collect urine output daily. However NHS guidelines are for the bags to be changed weekly to mitigate the risk of infections. The catheter and the leg bags are sterile when first used, the urine drains down into the bag and there is a flat, soft, non-return valve to prevent backflow up the catheter and into the bladder. Each time a leg bag is changed the catheter tubing is exposed, which is why it should be changed wearing sterile gloves and only once a week to prevent infection, the more times it is exposed, the higher the risk of cross infection. The person had been tested positive for a UTI in June 2017 and their antibiotic was changed. This meant that there was a possibility that they developed the UTI because staff were changing the bags too often and increased the risk of infections.

We found that where people were identified at risk of developing pressure ulcers they had the right equipment in place to mitigate the risks. However we saw people left sitting in their wheelchair for considerable amount of time and although they were sitting on a pressure cushion to prevent pressure ulcers developing, wheelchairs are not recommended for sitting long periods of time unless they are specially designed for people. People`s care plans had not contained sufficient details for staff to know how effectively manage and prevent pressure ulcers developing. For example there were no details of what type of pressure mattress should be used or if people needed pressure cushions when sitting.

We found that a significant number of people were having food supplements prescribed to them by their GP`s because they were losing weight. Although staff told us they provided smoothies to people it was not clear how staff supported people to have a good food and fluid intake. Care plans were not detailed sufficiently to instruct staff how to support people at risk of malnutrition with a high calorie diet and if their food should have been routinely fortified by the kitchen staff.

People had their weight monitored regularly and staff used a tool to identify if people were at risk of malnutrition (MUST). Food and fluid charts we looked at did not give guidance on what was the recommended amount of fluid people should have had in a 24 hour period. Food and fluid charts were poorly completed and often we saw gaps in recording. Staff did not total to see how much people drank in a 24 hour period. As a result people`s food and fluid intake could not be effectively reviewed to assess if they needed more support or treatment because the records were not reflective of the fluid and food they consumed. This meant that staff failed to effectively manage the risks of malnutrition and dehydration.

Care plans were more generic in detailing what staff would have to do if people had catheters or were at risk of pressure ulcers. For example there were no detailed plans for people who had a catheter to describe what size of catheter they needed, how often this had to be changed. There were no details of the type of mattress or the settings these had to be on for people at risk of developing pressure ulcers. There were no details in care plans if people preferred to sit in their wheelchairs how the risks of developing pressure ulcers should be managed.

We found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people's health and welfare were not sufficiently mitigated to keep people safe.

In some areas of the home the environment was not tidy, clean or fresh. For example we found that the treatment room floor was dirty and had debris present on it. We asked nursing staff if the housekeepers had access to the room and they said no. The room was disorganised and contained a mixture or paperwork ready to be archived and wound dressings together with other clinical equipment some of which had expired in January 2017. The nursing staff told us that they did not regularly checked the treatment room and the equipment to check if the equipment they had was still in date or not. This was an area in need of improvement.

People gave us mixed feedback when we asked if they felt that there were enough staff to meet their needs. One person said, "When I use the call bell they come and assist me quickly." Another person said, "I don't think there are enough [staff]. When they come in to help me they are always rushing and I feel sorry for them [staff]." A third person said, "They are very good in answering the call bell but when we sit here [communal areas] sometimes there are no staff around and I worry because I cannot call for help."

Staff told us they felt there were enough staff and they could deliver the care and support people needed, however they told us if a staff member reported absent this caused difficulties to the team. One staff member said, "I think we are enough staff and we don't use agency. When some staff calls in sick then it is hard. It would be nice to have more time to spend with people but we can get the work done." Another staff member said, "Breakfast times are busy, there are enough staff but when people go off sick it's harder. We allocate staff their duties."

We saw that the provider had a dependency tool which staff completed monthly to ensure they had the appropriate staffing levels in the home. The provider ensured that the staffing levels based on the tool were maintained however they had not considered staff deployment for different times in the day when more

people needed assistance in the same time. For example in the morning when people were getting up and needed staff`s help for personal care and breakfast. We saw that some people were still waiting to be assisted by staff after 11am. We also found that two people who were identified as high nutritional needs by staff in their care plans the dependency assessment were completed as medium needs. This meant that there was a possibility that not all the assessment were completed correctly when assessing people`s dependencies. This was an area in need of improvement.

There was information and guidance displayed about how to recognise the signs of potential abuse and report concerns, together with relevant contact numbers. We asked staff how they kept people safe and one staff told us, "Make sure we check who strangers are and use the correct equipment. If I had any concerns I would report them to the nurse in charge." Staff were aware of how to escalate their concerns and report to outside professionals such as the local authority or the Care Quality Commission.

There were safe and robust recruitment processes in place to make sure staff employed were able, fit and suitable to work with vulnerable people. Appropriate checks had been undertaken before staff started work including written references, satisfactory Disclosure and Barring Service clearance (DBS), employment history and evidence of the applicants' identity.

There were suitable arrangements for the safe storage and management of people's medicines. People were supported to take their medicines by staff that were properly trained. Nursing staff had access to guidance about how to support people with their medicines. We observed a nurse administering medicines to people. They explained the person what their medicines were and why they had to take them. Medication Administration Records (MAR) were completed once staff observed the person taking their medicine. We checked a random sample of boxed medicines and found that the sock agreed with the records maintained. However the management of medicines prescribed as and when required needed reviewing as the recordings on the Mar when people had variable dose like one or two tablets was not accurate. This meant that we were not able to check if the stock was correct as staff not always recorded clearly when they gave one or two tablets to people.

Plans and guidance were available to help staff deal with unforeseen events and emergencies which included relevant training such as first aid and fire safety. For example, the fire alarm systems were regularly tested and fire drills were organised to include day and night staff. However we found that people`s personal evacuation plans in the event of a fire were not always completed accurately. For example for one person only the first half of the assessment was completed without concluding how staff should assist the person to evacuate and what equipment to use. For another person the assessment concluded that two staff should hoist the person to a wheelchair and help them evacuate. We asked the regional support manager to ensure the assessments were reviewed for people as current staffing arrangement during the night would not allow for a safe evacuation for people.

Requires Improvement

Is the service effective?

Our findings

People told us that they felt the staff were sufficiently skilled to care for them. One person told us, "The recovery I had, it`s due to the help I got from staff and my positive mind-set." Another person said, "They put cream on my legs, twice a day. They always do it." A relative told us, "[Person] has good care, I am happy that they are here."

Newly employed staff completed an induction programme, during which they received training relevant to their roles. Staff received the provider's mandatory training and regular updates in a range of subjects designed to help them perform their roles effectively. This included areas such as moving and handling, medicines and infection control. Staff had opportunities to develop their knowledge further. The provider offered more specialist training for staff. For example two staff we spoke with had been trained to deliver training in the home in topics like health and safety and infection control. One staff member said, "I am up to date with my training."

Nursing staff were supported to keep up to date with their professional registration. One nurse told us, "We get regular training; my validation hours are already complete. 35 hours of training with the Nursing and Midwifery Council (NMC)."

Staff felt supported by the manager and were actively encouraged to have their say about any concerns they had in how the service operated. Staff attended meetings and discussed issues that were important to them. One staff member said, "We had a staff meeting last week." Staff we spoke with confirmed they had supervisions where their performance and development were reviewed. A staff member commented, "I feel supported by the new management team."
Staff understood the importance of ensuring people gave their consent to the care and support they received. One staff member said, "Assume people have capacity, if someone is confused it could mean they have a UTI. Choice is important as they might not like the options we give them." Another staff member said, "I encourage independence to ensure they [people] feel good about themselves and don't lose their skills."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection, we found that all the people who were considered to require a DoLS, had one submitted and were awaiting a decision by the local authority.

People where needed had their mental capacity assessed and if they lacked capacity certain decisions were made in their best interest following a best interest process. However for one person we found that different parts of their care plan detailed that they lack mental capacity to take decisions regarding their care,

however the mental capacity assessment was not completed to show how staff assessed the person`s capacity. We also found that a person`s care plan detailed that they had capacity to take decisions regarding their care, however when we talked to staff they told us that the person had short term memory problems. We saw that staff recorded in their notes that this person has asked to return to their own home. A mental capacity assessment had not been carried out to formally assess if this person had or not capacity to take this decision. The regional support manager told us they were going to address this as a matter of urgency. This was an area in need of improvement.

People were supported to eat healthy meals and had their likes and dislikes noted. One person said, "The food is good I have no complaints." Another person told us, "The food is brilliant. We have enough choices and it`s very tasty." We heard staff asking people what they wanted to eat from the menu. We spoke with the chef who showed us a profile of everyone's nutritional requirements, this included texture of the food and special diets. People's needs were noted on the white board in the kitchen to ensure they received the right food.

People were seen regularly by health care professionals about their general health. Records showed referrals to GP`s, tissue viability nurse, speech and language therapist, dietician and chiropodist.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with were very positive about the care they received. People we spoke with confirmed staff were kind and respected their dignity. One person said, "Staff are wonderful I have no complaints." Another person said, "I do feel comfortable with staff regarding my dignity." One relative told us, "Staff are courteous and caring and we can have a laugh."

However we noted throughout the home most people's doors were left open and this did not ensure their dignity was maintained. Staff only closed bedroom doors whilst personal care was in progress. Some people were able to tell us that they did not mind that staff were leaving their bedroom doors open, however they also told us that staff didn't ask if they wanted their door opened or closed. Staff we spoke with told us that people wanted their doors open and that it was easier for them to be able to keep an eye on people.

Staff had not considered that by leaving bedroom doors open visitors and people who lived at the home were able to see people in their beds that were asleep and not always covered. In some bedrooms there were continence pads left visible from the corridors. This had a negative impact on people`s dignity as visitors could see that they had a continence issue. For example, we observed one person was visible from the corridor who was vomiting into a bowl. A staff member had gone to tell the nurse that the person needed help but had no considered to ring the call bell for assistance or close the door to give the person some privacy and maintain their dignity.

We also observed a person who staff told us was nearing the end of their life. We observed this person in their room, the door was left open and they were lying on their back with their neck extended, their mouth wide open and their breathing was laboured. This could have been distressing to see for visitors or other people living in the home.

We also found that the environment and staff were noisy at times and not always promoted calm and relaxed atmosphere. One relative told us, "The only thing I find [complaint] is that the staff can be quiet loud." At lunch time we observed housekeeping staff hoovering the corridors. The noise from the hoover released the door guards and bedroom doors automatically shut. This could have been disruptive for the people in their bedrooms trying to eat their lunch.

We found that people`s dignity and privacy was not always promoted by staff`s actions and therefore the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed kind interaction from staff and staff spoke to people in a respectful way. Staff were at times rushed and it was not always easy to find them but they were kind and caring at all times.

On entering the home there was a reception area and a lounge with seating in the window and around the wall area. There was a hot drinks machine, a small fridge with milk in, cups and glasses, biscuits and a tray with snacks on. We observed people using this area to meet their family members. We observed children

sitting on the carpeted floor playing a game whilst visiting their grandparents or great grandparents. The atmosphere was friendly and we observed staff talking to relatives in an open manner, they gave eye contact and smiled. This clearly suggested that staff had a good and trusting relationship with people and their families. Relatives told us they always felt welcomed by staff and the main reason people moved into the home was the homely atmosphere and the friendliness of staff.

People and relatives told us they felt involved in the day to day decisions made about their care and support needs. One person told us, "I am very independent and I can decide on what and when I want to do things. I know about my care plan and I do have a say." Another person said, "Oh yes! I think I remember having a care plan but I don't know what`s in it now."

When we reviewed people's care records we were able to see that some discussions had been held with people, and where appropriate, their relatives about their care needs. For example people were involved in decisions around their future treatment. Some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place and they were clearly involved in making the decision themselves.

Staff told us that at the commencement of each shift they discussed people's needs and whether there had been any changes. When we checked the handover form there was a list of people who had a DNACPR decision in place. However we found that a person who told us they had took the decision to have this in place since January 2017 had not been listed on the handover form as having this. This meant that there was a risk that staff could take the wrong decision regarding treatment for people in case of emergency if they referred to the handover form. One nurse we discussed this with told us they were taking immediate action to correct this.

People's care records were stored in a lockable cabinet in the nurse's station in order to maintain the dignity and confidentiality of people who used the service.

Requires Improvement

Is the service responsive?

Our findings

Some people told us that staff knew what they liked and disliked and they had enough choices, other people said that staff were not always mindful of what they liked or preferred. One person said, "They [staff] know what I like and they are very good. It`s nice to have a connection with staff." Another person said, "It's quite good living here, I grumble sometimes, because staff leave my bathroom door open sometimes and I can't see the clock on the wall." A third person said, "It`s the little things which at times are annoying. Like they don't draw the curtains, or they don't switch the light off when they go. Some staff will talk more and that`s nice but some are not talking much. I assume we are all different."

Care plans did not give current information to the staff and nurses about people`s current needs. We found conflicting information in people`s care plans. For example one person`s care plan detailed that they had no hearing impairment. When we talked to the person they told us they could not hear us properly because they wore hearing aids and staff were not able to help them to put them in. When we looked at this person`s care plan there was no records of when the person got their hearing aids and the care plan was not updated to reflect the use of hearing aids. There was no guidance for staff on how to care for them or guidance on how to insert them.

We found that there were people who were having food supplements and they refused to drink those because they did not like the taste. Staff were not documenting what methods they were utilising to encourage food intake. People`s food likes and dislikes were not documented and there were no personalised plans for staff to follow to ensure that people who were at risk of malnutrition were encouraged to eat more by offering them their favourite foods.

For the lack of personalisation of the care and support people received we found the provider in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain their interests and to take part in activities which they enjoyed. For example, people were supported to attend activities that included baking, reminiscence, movement to music, games and quizzes. The activity coordinator told us that they promoted healthy exercises for people. They completed a 24 week programme `Smile` offered by a reputable care providers association. This was to prevent hospital admissions for people through reducing falls using exercises to improve people's mobility. They told us, "We now have a booklet of exercises for people to do."

On the day of our inspection some people had been supported to access the community and we noted activities were provided throughout the day. People who were not able to attend activities were visited by the activity coordinator for one to one support. However due to the high number of people who were permanently in their bedrooms more activities were needed to ensure they had social interaction. The provider was in the process of recruiting an additional activity coordinator to meet people`s needs. Every person received a copy of the residents meetings and the monthly planned activities to ensure they knew what activities were available and when.

People and their relatives told us they felt they could approach both staff and the management team if they were unhappy with the any aspect of the service. One person told us, "I can raise any concerns any time. Staff is very good in solving any issue I have." Complaints were recorded and reported to the manager for further investigation. The outcome of these investigations was noted, and where necessary reviewed with the regional manager. We saw that a complaints policy was made freely available to people, relatives and visitors to the service and this also signposted people to external organisations for support.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff told us they felt the management team was approachable, supportive and listened to their views and opinions. They told us that the manager led by example and felt that they were open and supportive. One person told us, "Yes I know the manager changed but they used to be the deputy here so it`s no change really." One relative told us, "We have good communication and we know the manager used to be the deputy."

We saw that quality audits were routinely undertaken for all aspects of the service. These were done by the manager, deputy manager and representatives of the provider`s senior management team. These included areas like medicines, health and safety, care plans, training and general observations around the home. Where shortfalls had been identified, the manager had developed an action plan which they discussed with the regional support manager. For example we found that the regional managers` audit identified in June 2017 that only 69 percent of the staff had up to date fire training. We found that the manager has provided training for staff and by the end of July 2017 there were 75 percent of the staff trained. The manager was working to achieve 90 percent by the end of August 2017.

We found that the audits carried out in the home had not identified all the issues we found during this inspection. For example the lack of personalisation in the care and support people received, care plans not up to date with current information, gaps in observation records. The lack of appropriate and effective recording in people`s care plans meant that their care and support could not be effectively reviewed.

At the previous inspection we found that people's care records had not always been completed in a legible manner where we were able to understand clearly what had been noted. Staff we spoke with were aware of people's current care needs, and told us they were kept informed by daily handover discussions of people's needs. However in some cases there was difficult to read what people`s care records said and what had changed in their condition.

At this inspection we found that this issue was still present. Care records were not legible and handover forms were not updated to contain current information about people. This meant that there was a risk that staff new to the home or visiting professionals would not have been able to clearly interpret what people's care needs were.

The regional support manager told us that the provider had a rolling re-decoration plan whereby they upgraded the bathrooms, toilets and other areas in the home. However we saw that some of the issues we identified were not picked up by the providers audits for example walls had stains, some of the toilets and bathrooms on the ground floor had lime scale around the taps, cracked tiles behind the toilet and rusty drains in the sinks. This meant that there was a risk that these had not been considered part of the re-decoration process.

For the lack of contemporaneous records and lack of effective audits to identify and improve the quality of the care people received we found the provider in breach of Regulation 17 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014

The home had a newly employed manager in post. People, relatives and staff were positive about the new manager. One staff member said, "[Manager] was the clinical lead, then deputy and now is the manager. I like [manager] they listen and advise you. "

People and their relatives told us that there were regular meetings held where they were kept informed of events and changes in the home. We saw that people had the opportunity to discuss the menu, activities and their suggestions were listened to.

There were also regular staff meetings where staff were given an opportunity to raise and discuss any issues they may have had which concerned the team and people living in the home. We saw that recently staffing were increased to 11 staff in the morning, however staff were still reporting that they worked under a lot of pressure especially during the morning when more people needed help at the same time. We saw that there were no alternatives considered by the manager or the provider other than the dependencies they used for staffing. There were no thoughts given to assess if different staff deployment could have had a positive effect. There was no consideration given to try and even out the length of time it took for the nursing staff to administer medicines to people. For example we saw that in the morning nursing staff were still administering medicines to people at 11 am. However when we looked at people`s medicines we found that a lot of medicines people took in the morning had been prescribed only once a day. Nursing staff could have agreed with people`s GP`s and administer some of the once a day medicines at lunch time when their medicine rounds only lasted one hour. This was an area in need of improvement.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that the care and support people received was personalised and took account of their likes, dislikes and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We found that people`s dignity and privacy was not always promoted by staff`s actions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks to people's health and welfare were sufficiently mitigated to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that people`s records were contemporaneous and legible. The providers quality assurance systems were not used effectively to identify and improve the quality of the care people received.