Strong Life Care Limited

Highstone Mews Care Home

Inspection report

Highstone Road
Barnsley
South Yorkshire
S70 4DX

Tel: 01266733966
Website: www.fshc.co.uk

Date of inspection visit:
09 September 2016
15 September 2016

Date of publication:
21 February 2017

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**

Summary of findings

Overall summary

The inspection took place on 9 & 15 September 2016. The registered provider had taken over the home in June 2016 and had introduced a new management team after a period where the home did not have a manager in post.

Highstone Mews is a care home registered to provide accommodation and residential or nursing care for up to 60 older people, some of who are living with dementia. The ground floor of the home is configured to provide personal care for up to 30 people. The first floor provides nursing care for up to 30 people and both floors support people who have a diagnosis of dementia. The registered provider told us they were planning to split the home into four smaller units to meet people's needs more efficiently.

There was no registered manager in place at the time of our inspection; however there was a newly appointed manager and deputy manager. 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.

People we spoke with gave mixed views about whether they were safely cared for in the home on the first day of the inspection, however people were feeling more positive about the level of safety on the second day.

Risk assessments were in place for all aspects of people's care, however we found that whilst a lot of work had been carried out between the first and second days there was still conflicting and inconsistent information present.

We found some concerns about the maintenance of the building, and there were some areas which had not been maintained as frequently as they needed to be.

There were personal emergency evacuation plans in place, however these did not contain key information about people's needs and there was no instruction to tell staff how to assist people from the building in the case of an emergency.

There had been concerns raised prior to the inspection that there were not enough staff to meet people's needs. We found there were staff from other services on the first day who did not know people or how to meet their needs. There had been an increase of regular staff when we returned on the second day which had led to an improvement in the level of care and support people were receiving.

There were multiple concerns about the management of medicines in the home. These included incorrect use of medicines, unsafe storage (due to temperature) and medicines being out of stock and unavailable to people.

The recruitment process in place was robust and all appropriate checks were made to ensure staff were of good character.

The service had not ensured there were appropriate Deprivation of Liberty Safeguards in place for all the people who required these. We found there had been work carried out to rectify this between our visits however there was still more work which needed to be completed to ensure people's rights were protected.

Staff training had been identified as an area of concern during an audit carried out prior to our inspection. We found there had been a programme of training planned and this was in progress to ensure staff had the relevant skills and knowledge to carry out their roles effectively.

We had received information of concern in relation to the amount and choice of food available to people, and concerns about people who had lost weight prior to our inspection. We found there were no concerns about the availability of food, however there had been some people who had suffered weight loss. The management team were taking action to ensure people were receiving the correct support to maintain a healthy diet and weight.

People had access to a range of healthcare professionals, including GPs, district nurses, opticians and chiropodists. We did find however that people who were living with some conditions were not being adequately monitored to ensure their conditions were stable.

Staff were kind, caring and sympathetic when supporting people and we saw there were some positive relationships within the home. We saw on the first day that some people appeared unkempt; however this had greatly improved when we returned for the second day.

We saw there were some occasions where people's dignity was not well protected and this was not always recognised by staff, for instance when people were in bed and became uncovered.

There was very little evidence that people had been encouraged to discuss their wishes for the end of their lives, to ensure this information was recorded whilst people had capacity to share their preferences.

We saw there were activities taking place in the home, and there were some outings which took place. We also found there were a significant number of people who remained in their rooms and were at risk of social isolation. This has been identified and there was planning taking place to ensure people had one to one activities in their rooms to lessen this risk, if they could not be encouraged to leave their rooms.

On the first day of the inspection we found care plans were confusing and chaotic as they were being maintained in part on an electronic system and in part on paper. This had changed when we returned for the second day as all the information had been put into the electronic system and the paper records had been archived.

There was no evidence that people or their relatives had any opportunity to be involved in the creation or review of their care plans, which meant their wishes and preferences were not gained and included in these documents.

The home had been without a manager for a period of several weeks. The newly appointed manager and deputy manager had only been in post for 10 days when the inspection started.

The implementation of the electronic system had been poorly planned and this had led to confusion and an

increased level of risk, however this was rectified between the first and second days of the inspection.

Staff were feeling more positive since the appointment of the manager and deputy manager; however they reported feeling unsettled by the recent changes and period where there was no manager.

There was some evidence of auditing and monitoring processes, which had been carried out by a supporting manager from another home, however there needed to be consistent checks carried out and actions plans created to ensure all actions had been carried out and in a timely manner.

We saw no evidence that there had been any senior manager or registered provider visits to check the quality and safety of the home, we were told these were planned to start the weekend following the inspection.

There had been little opportunity for people and their relatives to give their thoughts and views on the changes which were taking place in the home, and whilst some people felt they had been kept informed others felt they had not.

The provider was not meeting the requirements of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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 home was not safe.

People we spoke with and their relatives did not all feel that people were safe at the home.

The management of medicines was not safe.

Risk assessments were not always accurate and did not identify specific risks and the measures which needed to be in place to keep people safe.

Is the service effective?

Requires Improvement

The home was not always effective.

There was a programme of staff training planned and in progress; however at the time of the inspection staff did not have all the skills and knowledge needed to meet people's needs.

There had been some mental capacity assessments carried out and the home was in the process of applying for Deprivation of Liberty Safeguards (DoLS). There had been some thought given to seeking and gaining people's consent to care, however this was not appropriately carried out and did not comply with the Mental Capacity Act 2005 (MCA)

We found there were issues with weight loss in the home, and this had not been identified in all cases. The assessments which were in place to assess nutritional need were not always accurate.

Is the service caring?

Requires Improvement

The service was not always caring.

The staff were kind and sympathetic when supporting people, however we observed that staff did not always recognise when people's dignity was not being protected.

Whilst we found some evidence that people had access to

advocates, this was not always the case, and in some cases where people did not have capacity to make their own decisions there was no information in their care records to show what support was in place to support them.

The care and support which was in place did not always give people the opportunity to maintain their independence as people were not encouraged to do things for themselves.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were in the process of being put into an electronic format; this had led to generic information being in people's care plans which did not relate to them.

Care plans were not person centred and whilst there was evidence that work had been done during the inspection to improve care plans we found there was still inaccurate information within them.

Social isolation was an issue as a number of people remained in their rooms, however the home had recognised this and were exploring ways to involve people and to offer them one to one activities where needed.

Is the service well-led?

Inadequate

The service was not well-led

The service had been without a manager for a period, which had led to poor standards of care and governance. There was a newly appointed management team who were working towards making all the required improvements.

There were some systems in place to monitor the quality and safety of the service, however further systems needed to be implemented and the registered provider needed to ensure they had oversight of the home's performance.

Records were disorganised, which was in part due to the change to an electronic system. There was intensive work taking place to complete the transition and ensure the records were accurate and up to date.

Highstone Mews 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 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 9 and 15 September 2016 and was unannounced. The inspection team comprised of three adult social care inspectors and an expert by experience on the first day and one adult social care inspector and a pharmacist inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had expertise in the care of older people and people who had a diagnosis of dementia.

On this occasion we did not ask the provider to complete a provider information return (PIR) as the inspection was not due to be carried out and had been brought forward due to concerns we had received.

Prior to the inspection we reviewed all the information we held on the home, including any notifications they had sent to us. We had received information of concern from multiple sources and we had discussed these concerns with the local authority commissioners who also had concerns about the quality and safety of the home.

During the course of the inspection we spoke with the manager, the deputy manager, a senior care worker, a nurse, seven care workers, a domestic, a housekeeper, a cook and the maintenance person. We looked at the care records (some paper based and some electronic) for eight people who lived at the home, current safety certificates, all records relating to the management of medicines, quality assurance, auditing and a variety of other records relating to the running of the home.

Inadequate

Is the service safe?

Our findings

People who lived at the home and their relatives had mixed views about the level of safety within the home. Some people told us they felt safe, whilst others said they felt there was not enough staff to keep them safe. People told us "I get fed up of waiting, staff say they will do it in a bit, but then don't" and "Staff do as much as they can for you but sometimes at the weekend, there just aren't enough staff". Conversely we were also told "The staff have helped me settle and I feel safe." and "I like it here the staff are good to me they keep us safe." One relative told us "When I came last Monday there was not enough staff, there were only two staff on this floor." and "Down here people's needs are too high and there are not enough staff."

Staff we spoke with had undertaken safeguarding training and were able to describe the types of abuse they would look for. Staff were able to describe who they would raise their concerns with and told us they would be confident to do so. One member of staff told us, "We are encouraged to report any concerns we have straightway."

We looked at risk assessments which had been recently completed on the electronic care system. The risk assessments covered all aspects of the person's care needs, including their dependency level, communication and senses, nutritional needs, skin integrity, mobility, overall health, mental health, mental capacity and care needs. We found the information contained in the risk assessments we reviewed was inconsistent and in some cases contradictory, for example there was conflicting information about the type of diabetes people had and the treatment they required to manage the condition.

We looked at the risk assessment for one person which was completed in August 2016, we found there was conflicting information in relation to the person's mental capacity and ability to make decisions, we also found there was information which showed they had been assessed as needing a 'repositioning schedule' which would only be needed if a person was not mobile and at high risk of pressure damage, however we observed the person was independently mobile.

The inconsistent and conflicting information which was contained in these risk assessments meant that people were at risk of harm, as the staff may access and act on information which is incorrect and could lead to care and support which is not appropriate to their needs.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the premises and whether all required safety checks had been carried out. We found that there had been some recent concerns about the safety of the building. There had been an incident where a fire alarm had gone off and the fire brigade had attended the home. The cause of the alarm was found to be a faulty light switch. The registered provider took immediate action to ensure this was rectified. We looked at the safety certificates for the building. We found the lift operation should have been checked quarterly, the last check we could find was dated 29/10/2015. Some of the medical equipment had not been checked since July 2014. We would expect to see this had been checked and serviced annually to ensure it was safe

and in working order. We also found the nurse call system was recorded as needing to be checked 07/10/2014, we could not find any evidence this had been carried out. We raised all the out of date certificates with the maintenance person for them to take appropriate action.

This was a breach of Regulation 15 Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the equipment which was in use to assist people who were unable to move independently, this included bath hoists and mobile hoists. We found the equipment was in a good state of repair and that it has been regularly serviced and checked by a qualified person.

We looked at the emergency business contingency plans which were available in the home, we found the only copy was from the previous provider and was dated January 2012. This plan was not suitable for current use due to the change of registered provider. We raised this with the registered provider who assured us they would rectify the shortfall as soon as possible.

We looked at the personal emergency evacuation plans (PEEPs) which were in place for people who lived at the home. The purpose PEEPs is to ensure staff know how to assist each person to leave the building safely in the event of an emergency. We looked at the PEEP for a person who had multiple risk factors for leaving the building which included vision impairment and a diagnosis of dementia. The PEEP stated the person 'requires full assistance from one member of staff'; there was no explanation of how staff should do this. We looked at another PEEP for a person who was a wheelchair user. The use of a wheelchair was not mentioned in the plan, the plan stated 'will require full assistance from one member of staff', the person was situated on the first floor of the building and there were no instructions to staff as to how they should assist the person to leave the building safely.

We saw the home provided equipment to aid staff assist people safely from the building in case of emergency including evacuation chairs and an emergency sledge (used to assist people with stairs). However there was no mention of this equipment being used in the PEEPS which were in place despite people needing assistance to be brought downstairs for example if they were in a wheelchair. We were assured staff had been trained in the use of the equipment as part of their fire safety training.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there had not been reasonable steps taken to mitigate the risks to people who used the service.

We looked at how accidents and incidents were being recorded. We found there was a newly created file which included a log of incidents for easy reference and a copy of the accident or incident form. The purpose of the file was to allow the manager to monitor accidents and incidents across the home. There had been no analysis of the information as the system was newly created. All accident and incidents were recorded on the electronic system to ensure they were easily accessible for each person.

We had received information of concern in relation to there not being sufficient staff on duty to meet people's needs and maintain their safety. We looked at the rotas which were in place. The rotas showed there were 11 staff on duty including a qualified nurse and a senior care worker. We found on the first day of inspection the number of staff who were on the rota did not match the number of staff who were on duty. This was because there had been additional staff brought to the home from another home in the registered provider's group of homes. We observed throughout the day that staff appeared very busy and there were

call bells which were not answered quickly.

We found the staff from the other home did not know the people they were supporting and had no knowledge of their needs. During the morning we observed there were four people in a lounge upstairs who were being supported to drink high calorie milkshakes. We asked the member of staff what the people's names were; they were unable to tell us the names of any of the people in the room. This was concerning as the people clearly had a high level of dependency and the staff did not know what their specific needs were, for instance if any of the people required thickened fluids to minimise the risk of them choking.

People we spoke with told us there were not enough staff to meet their needs and relatives agreed this was the case. One person told us, "You sometimes have to wait for things when they are short staffed" and another person told us, "The staffing levels are very low at weekends." Not all relatives we spoke with were confident that their relatives were safe and well cared for, some expressed they felt that there were times when people were not supervised as there were not enough staff. A relative told us, "I just don't think there are enough staff at times, it varies so much." A member of staff told us, "The residents here are so dependant it is sometimes a struggle."

We observed during the inspection that people were left unsupervised in the small lounges in the home for long periods. On one occasion a member of the inspection team needed to summon help for a person who had been left unattended in the upstairs activities room as one person was pushing another person around in a wheeled chair and 'banging them into the furniture'. The only member of staff they could find did not know the people's needs or names, but did intervene to stop the person coming to harm.

Relatives commented to us throughout the first day that there appeared to be more staff than usual present in the home and one relative said, "I think some staff have been brought in from the other home for today." One of the staff who had come from another home told us, "I don't know any of the residents - I am from another home - I have just come for today."

There was a manager from another home who had been offering support to the home during the first day of inspection. They told us they had carried out a dependency assessment on all the people who lived in the home, and they had used this to work out how many staff were required to meet people's needs safely. We reviewed the information they had given us and found that not all people who currently lived at the home were included in the calculation. The manager told us they felt the assessment they had used was not adequate as it was designed for a residential home and did not recognise the higher dependency of people who had nursing care needs. When we returned on the second day the manager had implemented a new dependency tool which did include people's nursing needs, which showed there needed to be more staff on duty on the nursing unit. This change to staffing had been implemented.

We identified there was an unusually high level of dependency in the home with very few people who were to any degree self-sufficient. This meant on the first day of the inspection staff were continuously busy trying to meet people's needs, and people who were in need of support were left unsupervised for periods of time. We observed this had improved with the new staffing levels on the second day.

We reviewed the recruitment process which was in place. We looked at the files for two recently recruited staff and found all the appropriate pre-employment checks had been carried out, including gaining a full employment history, seeking references from previous employers and a disclosure and barring service (DBS) check to ensure staff were of good character.

We looked at 15 Medicines Administration Records (MARs) and spoke with one agency nurse and one senior

carer. Medicines were stored securely in locked treatment rooms and access was restricted to authorised staff. Unwanted medicines were disposed of in accordance with waste regulations.
We checked procedures for the safe handling of controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found that these were not always handled appropriately and that standard operating procedures did not provide sufficient guidance for staff. We found that they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. However, there were controlled drugs in the cupboards that could not be accounted for in the current register and that there were entries in the register, which could not be found in the cupboard. We found that the register had been amended when one capsule could not be accounted for but this had not been notified to the manager or investigated, however we found this capsule during the inspection.

Room temperatures on the first floor where medicines were stored were recorded regularly but not always daily. Temperatures had been recorded above the recommended range on eight occasions in August 2016 and on seven occasions in September 2016. No action had been recorded by staff. In August 2016 records showed that fridge temperatures had not been recorded on nine occasions and temperatures had exceeded the recommended range on seven occasions on the first floor. We were informed that a new fridge had been ordered, however no actions had been taken to use the homes second medicines fridge on the ground floor. On the ground floor records were only available for two days in September; past records were not provided during our inspection. This meant we could not be sure these medicines were being stored appropriately or were safe to use.

We reviewed the homes medicines policy and found that it did not provide sufficient detail to guide staff, for example there was no guidance on administration of medicines including creams, eye drops or inhalers. The policy did not include what to do in the event of a refusal, covert administration, and it did not refer to the homes administration/refusal codes. The policy stated each MAR must have a current photograph to aid recognition of people during administration; however 10 records did not have photographs. We found medicines without labels so we could not identify which person they belonged to. We found medicines opened but no date of opening or amended expiry had been documented. This increases the risk of people not being administered their medicines in a timely manner or receiving medicines which do not belong to them.

We found MARs were not completed accurately and medicines were not always administered as prescribed. Two people's MARs which had been handwritten had not been completed correctly; we saw a further MAR where the dose had not been recorded correctly, we brought this to the attention of the manager during our visit. A second person check had not been carried out by nursing staff, to confirm the medicine details had been completed accurately, which was not in line the home's policy. We found that signatures did not tally with stock levels indicating that medicines had been signed as administered but not given and that carried forward values were not always recorded. We found that some records were blank and no code was recorded to explain why medicines had not been administered. We found that on two occasions for one person a pain killer had been administered five times daily instead of the maximum dose of four times daily; this increases the risk of toxicity. We found that three people who were prescribed transdermal patches had not had the area of application rotated in line with manufacturer's guidance; this increases the risk of sensitisation and skin breakdown at the application site. For one person the use of transdermal patches was not documented in their medication risk assessment. On the day of our visit one person had run out of their antipsychotic medicine three days previously and no action had been taken. This medicine was also not recorded in their online active medication list. A second person had run out of two medicines on the day of our visit, when we asked the carer if these had been ordered they stated they had not received this information at handover and so had not ordered a new supply. We brought this to the attention of the home

manager who addressed these issues.

There was a lack of written guidance to enable staff to safely administer medicines which were prescribed as and when required. For example, records were not up to date and some people who had previously been taking laxatives when required had then been prescribed them regularly but no update to care plans had occurred. For others there was no guidance to identify if pain medicines were required and some people had regular pain medicines prescribed but this had been refused but not reviewed. In addition, when staff did administer as and when required medicines they did not record the reasons for administration so it was not possible to tell whether these medicines had achieved the desired effect.

There was a lack of oversight with respect to medicines management and no system of audit to drive forward improvement. The policy stated that medicines audits should be carried out weekly, however the manager could not provide us with any completed audits or actions resulting from identified concerns.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed after lunch a person was being assisted by a member of staff to leave the dining area when they had finished their meal. We observed the person was in a wheelchair, there were no footplates for the person to place their feet on. The member of staff pulled the wheelchair backwards up the corridor. The person who was in the wheelchair did not have any shoes on and was only wearing socks; their feet were dragging on the ground whilst they were being moved. We were concerned about this as this could cause injury to the person's feet due to friction.

We looked at the standard of cleanliness in the home. We observed there were areas of the home which were not clean and there were areas which were malodorous. Relatives we spoke with all said they were aware of areas of the home which were not clean and confirmed there were often malodours present. We observed that the most unpleasant odour was present upstairs, the odour increased as the day progressed. The newly appointed manager told us they believed the odour was caused by the current carpets, and advised they were in the process of having the carpets replaced with cushion flooring. We found there was a lack of personal protective equipment (gloves and aprons) in the upstairs bathrooms and some of the soap dispensers were broken and there were no paper hand towels available.

Relatives we spoke with told us, "Sometimes it really smells around here", "We know the environment is poor in places - we have been reassured by the new owners that this is going to improve" and "They [owners] have told us that they are going to invest a lot on money in the home."

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People we spoke with gave us varying opinions of the food which was served in the home. People told us, "Sometimes it's [the food] cold and it looks like slop" and "There is not enough fresh veg or fresh fruit." Whilst other people said, "The meals are lovely, the salads are my favourite" and "The food is alright, it is just beginning to pick up."

We spoke with some relatives who commented, "There are too many people in the dining room, it gets really loud at times", "I don't really know what [relative] gets to eat every day, there is no menu, well I've never seen one" and "The staff are lovely but I am not sure they fully understand the needs of people with dementia."

The manager who was supporting from another home told us they had carried out a full audit of the staff training and had identified that the level of training was poor within the home. The registered provider had undertaken to retrain all staff to ensure they had the relevant skills and knowledge. The manager told us they had planned all necessary training courses to rectify this and told us the level of compliance with staff training was at 60% at the time of the audit. We saw there were training courses which had been attended over recent weeks and there were multiple training sessions planned in for the coming weeks to achieve a good level of compliance. These courses included end of life care, infection control, dementia care and tissue viability. This showed the registered provider had taken timely action to ensure all staff were appropriately trained and skilled to carry out their roles effectively.

We spoke with staff who told us they had not received regular supervision over recent months, some of which pre-dated the current registered provider. We looked at the records and they confirmed this was the case. There had been no recent supervisions, however this had been identified and the newly appointed manager had planned in supervision sessions for all staff within the next month. Supervision is an important part of supporting care staff, as it is the manager's opportunity to embed and test learning and to remind staff of policies and procedures. Supervision also gives staff access to more senior staff to ask questions on a one to one basis and explore their understanding of various aspects of their roles and discuss any needs of people they support.

Some of the staff we spoke with had received an appraisal the previous year and some had not yet been at the home for a year. The newly appointed manager told us they would ensure all staff received their annual appraisal as they became due.

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). We spoke with the newly appointed manager and asked how many people had a current DoLS in place. The newly appointed manager had requested a status update of DoLS applications for everyone who lived at the home from the local authority to ensure they were fully up to date. On the second day we saw the deputy manager and the supporting manager from another home had made applications to the relevant local authorities for DoLS for everyone in the home who had been assessed as needing an authorisation.

We found during day one of the inspection there was a person who was being supported in a restrictive manner as they had a member of staff with them at all times. We looked at the care records for this person and found there had been no recognition of the level of restriction which was in place and no application for a DoLS had been made. We also found there had been no best interest decision made in relation to the person receiving one to one care which was necessary as they had been deemed not to have the capacity to consent themselves. There had been an urgent request for a DoLS made when we visited on the second day.

We found in one person's care plan there was a description of the person's capacity, which said they had very limited understanding of what was being said to them, yet the consent section of the care plan described how the person had their rights to refuse or consent to care explained to them and that they had given their consent. We found in another case the same consent wording was in their care plan and there was strong evidence they did not have the mental capacity to make their own decisions relating to their care. We discussed the need for a best interest decision to be made and documented in these cases with the newly appointed manager, who assured us they would ensure appropriate consent would be gained for everyone in the home.

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

We spoke with a health professional who was visiting the home, who said staff informed them there was a 'no restraint' policy in operation at the home. However information they had been given suggested this was not the case, this was in relation to the number of staff who had been involved in delivering personal care to the person.

We asked whether the home was clear about where people had a power of attorney (POA) in place and what powers these covered. We were told there were no copies of POA's contained within people's care records and we found this to be the case. We discussed the need to have evidence of the legal powers people had over the health and well-being of people who resided at the home to ensure decisions made were valid. We found there was a marker on people's care records which showed whether they had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place, and this would be clearly marked when a staff member printed off 'an emergency pack' which would be given to emergency services for instance with all the person's key information.

We had received information of concern which related to the food which was being served at the home and weight loss which had resulted from poor food choices and lack of access to food over a weekend.

We found during the inspection that there was no shortage of food, and there was a snack basket in the reception area, which contained crisps and chocolate biscuits. We also observed there was a snack trolley which went round in the morning, offering hot drinks, sweet snacks and fruit.

We saw on the afternoon of the first day that a person who had a diagnosis of diabetes which required

dietary control accessed significant amounts of chocolate from the snack basket in reception. This was unnoticed and unchallenged by staff. Whilst it is good practice that snacks be freely available to people it is also important that some monitoring is in place to ensure people who may not have capacity to make their own decisions are not putting themselves at risk due to their medical conditions. We discussed this with the newly appointed manager who had changed the snacks to plain biscuits when we returned on the second day to lessen the risk.

We observed breakfast was served in small rooms throughout the home, and this appeared to be relaxed as breakfast was served over a long period, as and when people chose to get up. We saw there were a significant number of people who ate in their rooms, staff told us this was by choice. We found that where people were served meals in their rooms, they were not served in a thoughtful or helpful manner. For instance where people were sat in chairs, meals were placed on tables at the side of them rather than the table being placed in front of the person. This meant that people lost interest in their meals and ate very little and in some cases the meals remained untouched. It was clear there were no staff available to encourage people to eat their meals when they stayed in their rooms.

We saw the dining experience in the dining areas was not positive and lacked choice. On the first day, there were glasses of water on the tables, no other drinks were offered, however on the second day we saw there was a choice of drinks offered including juice and hot drinks. There were no condiments available or offered to people to allow them to season their meals to their own taste. We also noted there was no choice of dessert on the first day of the inspection.

We also noted on the first day the staff were trying to be calm and patient when encouraging people to the dining tables. This was however a very chaotic period with people repeatedly leaving the dining area and staff immediately returning them. This resulted in a very loud environment which not a calm or pleasant experience for people living with a variety of mental health problems. We saw this had improved on the second day of the inspection.

People were asked to choose their meal from the day's choices during the morning; however as some people were living with a diagnosis of dementia they were not able to remember what option they had chosen. We saw there were some menus displayed around the home; however these were in small print and were not accessible as they were high up. There were pictures of food available in the home however these did not refer to the foods which were being served. Relatives told us they had not seen menus displayed and did not know what their relatives ate.

Some people were complimentary about the food and told us the standards had improved recently, however other people told us the food was poorly presented and was not always hot when it reached them.

We spoke with the cook on duty who told us they had no budgetary restraints placed on the food they provided. We asked what happened if people did not like the choices which were on offer, they told us, "Staff should inform me if a person leaves their food then I will make them an alternative. I will cook anything the residents ask for." We did not see anyone being offered an alternative during the meals we observed being served.

We looked at the weight records which were kept. We were given a report from the new electronic system which did not show historical weights in most cases, however there were a few instances where it was clear there had been significant weight loss in a short timescale, for example nine kilograms in five weeks. This weight loss had not been flagged as a concern. On the second day of inspection we found the historic

weights had been inputted for most people, however there were weights which were unlikely to be correctly recorded, as they showed a loss of 10kg which had been regained the following week. The electronic system should flag concerns with weight loss, however these incorrect weights were preventing it from doing so. This was discussed and it was agreed the weight records would be revisited.

We looked at whether people had access to healthcare services and whether this was facilitated in a timely manner. All the relatives we spoke with told us the staff looked after people properly and their relative's saw healthcare professionals when they needed to including GP's, opticians and specialist nurses. One relative said '[Relative] always gets to see the specialist nurse" and another commented, "[Relative] has a whole range of healthcare professionals coming in, staff are great at communicating this." We saw there were a range of health professionals visiting the home on both days of the inspection.

We looked at the healthcare records of some of the people who lived at the home, and found their health needs were not being well-managed. We found this was particularly the case for people with diabetes. Daily records showed that there had been regular refusals to have blood sugar levels checked which resulted in staff not administering insulin as they were unable to calculate the amount needed. There was little evidence any medical advice had been sought to find out what action was required to ensure the person did not suffer any ill effects. There was no guidance for staff in the person's care plan to say what action should be taken to protect the person from harm. There was also another person who on the first day of inspection was displaying clear signs of their diabetes being poorly controlled. This was identified by a visiting health professional who took action to ensure this was corrected.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the environment and whether it had been adapted to meet people's specific needs. We found that whilst the environment pleasant, there had been little thought given to the needs of people who were living with dementia. The corridors were all very similar, which meant people did not have points of reference to help them negotiate through the home. There were door signs which included photographs of people on the first floor, but this was not throughout the home and there were people living with dementia on both floors. We found there were significant improvements needed to make the home 'dementia friendly'. We spoke with the newly appointed deputy manager who was a qualified mental health nurse, they told us they had extensive plans to change the environment to meet people's needs, which included separating the home into smaller units, changing the décor to give points of reference and adding reminiscence boxes outside people's rooms to help them recognise their own room.

Requires Improvement

Is the service caring?

Our findings

People told us, "The staff are alright - they look after me", "I dread it - when I hear that the agency staff are working - they don't know me or my needs" and "The night agency staff can be quite brusque sometimes." There were some staff who were referred to in very positive terms for example, "The night staff are alright - one person [care staff] is an absolute angel - they are very professional."

Relatives told us "There is member of staff - they make my [relative] laugh - they always go above and beyond - nothing is too much trouble for them" and "We come every day - so we get a good idea of what's going on - the staff are great with [relative]."

We observed staff were kind, caring and considerate when supporting people. Staff were friendly in their approaches however whilst some staff knew people well, there were other staff who did not know any of the people they were assisting. We saw there were good relationships between some staff and the people who lived at the home, and the newly appointed manager and deputy manager had taken time to get to know people and were visible in the home interacting with people throughout the inspection. We also found there were staff who had worked at the home for a number of years who did not know the last names of people they supported.

We found there were some people in the home who had particular needs and conditions which were not well understood by staff, which meant incidents of challenging behaviour occurred as staff did not know how to interact with people to meet these specific needs. This was evident as the newly appointed deputy manager had built a positive cooperative relationship with one person who had previously been very resistant to accepting support from staff and had made significant progress with them in a very short time.

There were some concerns about the behaviour of some of the people who lived at the home being challenging to others, and whether the home was an appropriate place for them to live. We spoke with a healthcare professional who had been asked to make an assessment of whether a person should be moved to another care setting. They told us they had been unable to assess the needs of the person as the person's needs were not being met in various regards which could affect their presentation and this meant they were not able to make a fair assessment of their long term needs.

We saw some people appeared unkempt and were not wearing clean clothing. We saw some people whose hair was not clean and people who were in need of shaving. Some people told us they were not able to bathe regularly as staff did not have the time to assist them. One person was very clear that they had waited several weeks for a bath, and when they received one the care staff said they would do this weekly, however when the week was up staff told the person they did not have the time to assist them. We saw from daily care records there were 'bed baths' recorded in most cases and bathing was not a regular occurrence in the cases we looked at.

We saw there were people who remained in their rooms and in bed, throughout the day. We noted that people were uncovered and parts of them were exposed as a result of being in bed. Their bedroom doors

were left open which meant visitors to the home were able to see them when they walked past. We saw people who had no shoes, only one shoe and we found odd shoes in lounges in the home. This showed that staff did recognise when people's dignity was being compromised and take appropriate action to protect it.

We observed and senior staff agreed there were elements of the care and support which were institutionalised. This was evident as staff moved people into particular rooms whilst other rooms remained unused, and the support which was offered was to achieve a task. For example when a member of staff would attend to a person to assist them to have a drink, we saw there was little interaction or opportunity to socialise during support. We saw during lunchtime there was a person who required a member of staff to feed them a soft diet. We saw the only communication was to ask the person to do things, there was no conversation attempted.

This was a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was little information in people's care plans in relation to their spiritual or cultural needs. We saw in one care plan a person held a religious belief, however it was also recorded they did not choose to practice this belief. The information in the care plan showed the person may not have the capacity to make this decision without support. One of the people we spoke with told us "We get a church service every month, I like it." This meant that whilst some people were having their spiritual needs met some people were perhaps not.

Care plans we reviewed were not written in a way which would remind staff that they needed to support and encourage people to maintain their independence. We did not see reference to encouraging people in the care plans we looked at. We observed that most people in the home needed a moderate to high level of support; however there would still be opportunities for staff to offer and encourage people to undertake basic tasks for themselves.

We saw from some of the care plans we reviewed that people had been identified as needing an advocate as there was concern they did not have sufficient mental capacity to make significant decisions without support, however in most cases we did not see any details of who their advocates were. We spoke with one person who did have capacity and they told us they spoke with their advocate regularly to keep them informed of what was going on within the home.

We noted from the care plans we reviewed there had been no information gained for people's wishes for the end of their lives. It is important to gain people's thoughts and preferences for how they would like the end of their lives when people come into a care setting as they may lose the ability to share the information over time. We discussed the importance of gaining this information with the newly appointed manager. We found on the second day of inspection that a form had been created to gather this information and that work was underway on completing these.

Requires Improvement

Is the service responsive?

Our findings

People told us, "I love it when the singers come, the games and things are not for me", "I like bingo, we don't play it very often" and "I have complained but sometimes I feel fobbed off."

Relatives told us, "I have complained to the new owners, they need time to sort things" and "I have never been asked what I think of the care, or asked to contribute to a care plan."

We found the registered provider was in the process of implementing an electronic system, which contained all care plans and records for people who lived at the home. The records were in transition from one system to the other at the time of our inspection.

We looked at the care plans which were in place for eight people who used the service. In one case we were given two files which contained different records relating to the same person, it was unclear why there were two files in place for the person, there were also electronic care records in place. We found there were daily care records within each of the two files supplied for one person dated 1 and 2 September 2016, despite being for the same dates the records were different, we asked the manager about this and they told us staff should not have been completing paper based records on these dates as there was now an electronic system in place where all daily records should be kept. This meant records relating to the care and support of the person had been recorded in three separate places over these two days. On the second day of inspection we noted that staff were now using the electronic system to input records about the care and support they had given.

We found the care records which we were given on the first day which were still paper based were not well organised or easy to read. For example at the front of one file we found a section which contained care plans, daily records, incident records and weight records. This meant it was very difficult to gain the key information for the person quickly, which would be critical in an emergency situation. We saw that all paper records had been transferred to the new system and the original records had been archived on the second day of the inspection.

We looked at some recently completed electronic care plans which had been created in August 2016. We found these were not person centred and used inappropriate phrasing which was not respectful of the people they referred to. For example one care plan referred to speaking to a person for a long period of time, causing 'a behaviour'. In the same care file we found the person was described as being 'bright and cheerful' yet had a diagnosis of depression and the care plan referred to 'appropriate behavioural strategies to calm them'.

There were no personal histories recorded for the people, which would give staff an insight into the person's character and personality, this was particularly important as there were a lot of people living at the home who would not be able to share this information with staff due to a diagnosis of dementia or poor health. This was discussed with the management team who had plans to complete 'my life' profiles for each person

as soon as they could complete this.

We found on the first day of the inspection the information contained within the electronic care plans was often generic and in some instances contradictory. For instance we reviewed the records for a person who was diabetic, there were sections which stated their diabetes was medicine controlled, yet another section showed there were only dietary controls required, however we found there was little evidence there were any controls to their diet from our observations. There was nothing in the care plan to assess their capacity to make decisions in relation to the management of their condition although their care plan showed they had been assessed as being high need in relation to their diagnosis of dementia. On the second day we saw there had been changes made to people's care plans and some of the generic information had been removed and some additional information had been added appropriately, however there was still further work to do to ensure care plans were person centred and up to date.

We found there was no evidence that people had been involved in the planning or review of their care plans, in three of the electronic care plans we reviewed we saw there was a statement which stated the person was not present when their assessment and care plan was completed. The importance of people and their relatives where they wished being involved in the creation and review of care plans was discussed with the management team.

The above examples demonstrate a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the activities which were in offer, and found that whilst some people found the activities stimulating and enjoyable there were a large number of people who did not access any of the activities. There were activities taking place on the first day of our inspection; however these were not pre-planned and just happened throughout the day. We noted there appeared to be the same three to four people involved in all the activities we saw taking place.

Relatives told us they felt activities needed to be more varied and more effort made to ensure they were suitable for people with dementia. Some people told us they had the chance to get out regularly, and people said they particularly enjoyed going out to the town centre shopping, however the planned trip on the first day of the inspection was cancelled due to staff sickness.

People felt there had been a decrease in the activities on offer over recent months. We spoke with one of the staff who was responsible for providing activities in the home, they told us they had been on leave and were not able to see what had happened in their absence as records had not been kept, they also told us activity equipment had gone missing or had been broken. One member of staff told us, "A lot of the activities equipment has gone missing over time, some gets broken, some thrown away and some I think is stolen." We saw there were some planned activities for the rest of the year including a full programme of Christmas activities. We discussed the lack of equipment which had been raised by staff with the manager who told us there were no barriers to them buying new equipment and they would ensure that this happened.

From our observations we saw there was little evidence of choice being offered. For example on the morning of the first day staff brought cups of high calorie milkshakes to a group of people, there was no choice offered of flavour and people were not asked if they wanted the drink, staff just helped them to drink what was provided. We saw people were taken to places and did not hear any conversations about whether they wanted to go or where they were going.

People and their relatives knew how to complain and they told us they would inform the staff if they were

unhappy with their care. People we spoke with told us, "I always say it like it is. I would say if I wasn't happy, I would tell [the administrator] if anything was wrong." Relatives told us they knew how to complain. One relative told us "My [relative] is happy here but I would go to the office if I had any concerns."

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. There was a newly appointed manager and deputy manager who had commenced their roles at the end of August 2016. There was also support being given by the registered manager of a nearby home which was also owned by the registered provider.

Staff we spoke with told us the home had been without a manager since the previous manager had left their post and the home had been supported by a manager from another home which was owned by the registered provider and an operations manager. Staff told us, "It worries us all about the management changes over the months," "All these changes in the management don't help staff morale" and "We have had so many managers in the office, I don't think I could go straight to the new manager, they don't know us yet".

Staff were positive in their feedback about the new management team and felt that they were beginning to see positive changes within the home. When we arrived on the second day the newly appointed manager told us the staff team had been extremely proactive in volunteering to work longer hours to help achieve the improvements which were necessary in the home.

We spoke with people who lived at the home about the recent changes of management, they told us, "The new manager is lovely", "I have not been here long, but the manager is very friendly" and "There is a new man in charge, he comes to see us all every day." A relative said, "I have met the new manager he made himself known as soon as I arrived today."

People also told us in relation to the change of ownership of the home, "There have been a lot of changes in a short time, it makes me nervous" and "The new owners plan to open more homes, I do hope they don't forget us." Relatives said "We have had some meetings with the new owners, I suppose they need time to change things," "The changes in the ownership and the management concern me" and "I have heard that they are going to make four different units. I hope the changes don't upset my [relative]."

We received mixed feedback from people and their relatives about communication they had received during the recent changes to the ownership and management of the home. Some people reported feeling involved in the changes whilst others said they had not had any input.

Staff told us they felt morale was generally better over the past couple of weeks, and one member of staff told us, "'I think we have a great staff team, we help each other." Staff felt on the first day that whilst staffing levels had improved they were still struggling to meet people's needs and this was affecting their morale. We saw there had been a visible improvement in the staffing levels on the second day.

The home was in a period of transition in a number of areas. There was a new registered provider, a new management team and there was a new electronic system being implemented. The effect of these rapid and multiple changes was the home appeared to be chaotic on the first day of the inspection. When we returned

for the second day however we found the home to be calmer and better organised.

The implementation of the electronic system had initially been poorly planned and managed. The paper based records were poorly maintained and organised and there were two systems running at the same time which was causing confusion. Staff had not all yet received training to use the new system, yet they were being expected to use it. There had been little thought given to how critical information would be available to staff, visiting healthcare professionals or in an emergency situation. Staff were not clear on what processes were in place which was evidenced by the daily records being both electronic and paper based on the same dates.

The records we looked at which had been created on the electronic system were in some cases generic notes which had been applied to multiple people within the home. The information did not relate specifically to them for example there was an entry which read, 'the following residents have been assisted to be washed and dressed this morning by staff' .The lack of personal records meant that should a person become ill for instance a health professional would not be able to assess from the daily records how they had been over recent days.

We asked to look at weight records for the people who lived at the home on the first day of the inspection, we were provided with a printed report. This report showed that when information had been put into the new system historic information had not been inputted, which made it impossible to see if some people had lost weight, the paper based records had been archived and were not freely available. We also found the report did not include all the people who were presently in the home. The report highlighted there had been significant weight loss for one person, however this had not been picked up and no action had been taken as a result. We discussed this with the newly appointed manager. We found on the second day of inspection that the historic information had been inputted, although there were some issues with some of the readings which had been recorded.

We spoke with the newly appointed manager who told us they had not yet commenced any auditing processes within the home as their priority was ensuring people were receiving care and support which met their needs. We were given some auditing which had been carried out by the previous manager. There was also auditing which had been carried out by the supporting manager from the other home. The auditing had picked up issues for instance the poor level of training and action had been carried out to resolve the matter, however there were other areas of concern which had been identified which had not yet been actioned, which included issues around the safe management of medicines.

The audits we reviewed included a domestic audit which had been carried out 28/06/2016, which showed a score of 73%. The audit identified odours in various areas of the home which were attributed to carpets; some of these odours were still evident during the inspection. There was a further domestic audit carried out 12/07/2016 which recorded a score of 52%. The odours which had been previously identified were again recorded; there were also lots of other issues including 'massive piles of unmarked clothes' in the laundry, dirty bathrooms, and dining areas which were dirty with stained chairs.

We did not find there had been any quality or monitoring processes carried out of the home by the registered provider, to ensure they were well informed of the homes performance and that they had oversight of the quality and safety of the home. We discussed this with the management team and they told us this process was due to start within the next few days and would be a regular programme of visits and checks.

There was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The quality assurance processes had not yet been implemented, although there had been resident and relative meetings booked in and the first of these had taken place on the second day of inspection. One relative told us, "I must say going to the relatives meeting is the way to change things." Another relative told us, "'Apparently there have been meetings with relatives. I wish we could get copies of the minutes then we would know what is happening. I can't always get to meetings."

We saw the home was making efforts to gain feedback as questionnaires were being given to health professionals and visitors to the home asking for their views. Some relatives we spoke with also said they had been involved in meetings with the owners and reported feeling they were listened to. We spoke with a health professional who told us they had seen very positive changes in the home since the new management team had started. They told us the staffing levels were much better and staff attitudes had improved significantly. They said they had problems finding staff and getting them to attend to people with them previously, but this had not been the case during their visit that day.

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 Care plans were not person centred and people were not involved in the creation or review of their care plans. Very little personal information and care plans were confused and contained conflicting information

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not recognise issues with people's dignity not being maintained - for example missing socks and shoes and people in bed uncovered with doors open - people being supported by staff who did not know their names.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	no evidence of consent being explained or gained in line with MCA - DoLS not compliant and issues with no evidence of POA's being in place which could lead to decisions being made by relatives who do not have the legal power to do so.

The enforcement action we took:

Wanring Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not safely managed despite being managed by qualified nurses in a lot of cases. There were issues with medicines not being ordered in a timely manner and being out of stock. Infection control issues and lack of adequate risk assessments particularly PEEPs.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	no management of the transition between paper and electronic systems - leading to chaotic records and inconsistent information in care plans and daily records being kept on multiple systems - lack of proper audits and where audits had been carried out these were not actioned to ensure the issues were rectified. No evidence of provider oversight since taking over the service.

The enforcement action we took:

Warning Notice