Sterling Care (Uk) Ltd

Highfield Residential 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

The inspection took place on 12 October 2016 and was unannounced.

Highfield Residential Care Home provides accommodation for up to 20 people, many of whom would be living with dementia. At the time of our inspection 13 people were living in the home.

The manager has been in post since January 2012. 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.

We had previously inspected this service on 23 and 24 April 2015. We did not find any breaches of the regulations but we did find a number of concerns which we asked the manager to address. We looked at these concerns throughout out most recent inspection to see if the manager had made improvements as a result.

We found that there was a clear lack of visible leadership in the home. Staff were unsure of who was responsible for the managerial tasks when the manager was not present. People who lived in the home did not know who the manager was. Whilst staff felt supported by the manager, they did not feel that the manager acted on their concerns. The manager asked for staff feedback but did not address any of the issues that staff raised.

We found a breach of the regulations as there was a lack of robust systems in place to routinely monitor and assess the quality of the service being delivered. There was no auditing to ensure that necessary health and safety checks were being carried out regularly and people's care records were not audited. The few audits that had been carried out had not been carried out objectively by an independent quality assurance system as stated on the service's website and had not identified the issues highlighted in this report. The latest rating was also not displayed on the service's website. This constituted a further breach of the regulations.

There were a number of areas of the service that were not safe and our findings constituted a breach of the regulations relating to the safe administration of medicines. People's medicines were not always managed or administered safely. People were not always given their medicines as prescribed and there was no regular auditing of medicines. Staffs' competency in this area was not assessed.

Whilst people we spoke with felt safe living in the home, risks to people had not been identified and steps had not always been taken to mitigate risks to people's personal safety and wellbeing. There were insufficient numbers of staff to adequately meet people's needs and attend to the day to day running of the service. People who were at risk of pressure ulcers were not repositioned as frequently as they should have been.

Safe recruitment procedures were not always followed.

People's care plans and risk assessments were not regularly reviewed and updated to reflect people's most current support needs and staff had difficulty in accessing them. People's care records were generic and did not detail people's individual care needs.

Another breach of the regulations was found as people were not always treated with dignity and their privacy was not consistently respected. Confidential information about people was spoken about openly. People's needs were not met in an individualised way. There was limited interaction between staff and the people who lived in the home, and there was a lack of activities for people to take part in.

Staff did not always receive training that was relevant to their role, including the provision of end of life care. New members of staff do not always receive an induction and training was not always updated.

People were not consulted about the food they ate and did not know in advance what they were being served. People told us that they enjoyed the food. People who were at risk of malnutrition did not have regular assessments carried out so their risk of malnutrition could be monitored.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. These safeguards protect the rights of adults using services by ensuring that, if there are any restrictions on their freedom and liberty, these are assessed by professionals who are trained to assess whether the restriction is needed. Decisions about two people going out on their own had been made for them when they had the capacity to make decisions for themselves. Appropriate DoLS applications for other people had been made to the relevant authorising body.

People were supported to access relevant healthcare professionals where concerns had been raised about their health or wellbeing.

Most staff had received training in safeguarding and staff were able to demonstrate that they knew how to report any concerns about abuse and what procedure they would follow.

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 consistently safe.

Risk assessments were not regularly reviewed or updated.

There was insufficient numbers of staff to support people.

Medicines were not administered as prescribed and staff competency in this area was not regularly assessed.

Staff were knowledgeable about safeguarding issues and knew how to report concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was not always up to date.

The service did not always act in accordance with the MCA.

People were not always supported to maintain a healthy nutritional intake.

People were supported to access relevant healthcare professionals where concerns had been raised.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was not consistently upheld.

People's confidentiality was not always maintained.

Staff did not regularly interact with the people who lived in the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans and risk assessments were not person centred or reviewed regularly.

Staff did not read people's care plans and were not consistently aware of people's most current support needs.

There was a complaints procedure in place and staff knew how to support people to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a clear lack of clear and visible leadership.

There was a lack of systems to routinely monitor and assess the quality of service being delivered.

Staff feedback on the service was not acted upon.

Highfield Residential 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 12 October 2016 and was unannounced. It was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we looked at information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we spoke with six people who were living at the home and one visitor. We also spoke with two members of staff, the manager and the cook. We looked in detail at the care records for four people and a selection of medical and health related records.

We also looked at the records for three members of staff in relation to recruitment as well as training and supervision records. We also reviewed a range of reports and audits undertaken by the manager.

Requires Improvement

Is the service safe?

Our findings

We found that the service was not consistently safe in a number of areas, including the safe storage, administration and management of medicines. We looked at three people's medicine administration record (MAR) charts. We saw that people were not receiving their medicines as the prescriber intended. We noted from one person's MAR chart that they had only received half of the prescribed dose of one of their medicines. We were told that this was because the medicine was out of stock and that no action had been taken. A member of staff informed us that they would contact the GP so more of the medicine could be ordered. We noticed a gap on another person's MAR chart where staff would sign to say that the medicine had been given. Therefore it was unclear as to whether the person had been given their medicine.

We noted that for another of the person's medicines that there were three missing signatures on the MAR chart. In addition to this we saw that a medicine cabinet in one person's room had the keys in it. This was a risk as there were medicines that were not secured. We noted that there were a number of people who were prescribed topical creams. We saw from one person's cream chart that they were prescribed a cream which needed to be applied twice a day. The chart showed that the cream was not always being applied as directed and sometimes it would not be applied for a number of days. Another person's cream chart did not give details about how often their cream needed to be applied or to which part of the body. This chart also showed that the person's cream had not been applied for a number of days. This could have potentially led to people experiencing discomfort as their creams had not been applied as directed.

Audits of medicines were carried out by a local pharmacy but there were no checks completed by staff. Such checks would potentially identify where medicines were not being administered as prescribed and when stocks of medicines were running low. One member of staff we spoke with told us, "I am not aware of any audits or checks on medicines and improvements are needed here." We spoke with the manager and they confirmed that the only audit carried out on people's medicines was done by the local pharmacy.

We asked the manager how they monitored and assessed staffs' competency in the safe handling of medicines. They told us, "I don't do staff competencies individually. I take their NVQ as competency." We saw from the staff training matrix that the staff who administered medicines had not had any training in this since March 2015.

The shortfalls found in the management of medicines constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection on 23 and 24 April 2015 identified concerns around insufficient levels of staff. This was because we found that the manager calculated the staffing levels on the numbers of people using the service and not on their specific needs. As a result we recommended that the manager referred to the current good practice guidance about how to ensure that staffing levels were appropriate and based on the assessments of people's dependency.

The manager showed us the most recent assessment of people's dependency. We noted that the

assessment had not been completed correctly. We were therefore unable to ascertain how staffing levels had been reviewed to meet people's needs. We noted from the dependency review that six people required a high level of support. This was primarily to support people with their personal care needs. We were told by one staff member on the day of our inspection that more than half of the people who lived in the home lived with dementia. We saw from the dependency review that very little time was allocated to supporting people who were living with dementia.

Whilst risks to people's health and wellbeing had been identified, the risk assessments were not always updated to reflect people's most current support needs. For example, we saw that one person was unable to swallow and they were also being cared for in bed. Their care plan was still guiding staff to encourage the person to eat full meals in spite of the person's diet being changed due to their swallowing difficulties. We did not see any documentation to show that a referral to the speech and language therapist had been made. We spoke about this with the manager and they told us that they had not reviewed people's care records since the deputy manager resigned a number of months previously.

We saw from some people's care records that they were at risk of choking and needed their food to be cut up. Whilst we saw that staff cut up people's food, the list of people and their nutritional needs in the kitchen was out of date as it did not list all of the people currently living in the home. This meant that the cook did not have the most current information regarding people's nutritional needs. We saw from one person's care record that they were at risk of malnutrition. It stated in the care plan that the Malnutrition Universal Screening Tool (MUST) should be used once a month to monitor their nutritional needs. MUST is a five step calculator for determining nutritional risk. It also provides guidelines about how to support a person who is at risk of malnutrition. We saw that the person's nutritional risk had not been calculated for three months. This meant that the person's nutritional risk was not being monitored and they would be at risk of not receiving a timely referral to relevant healthcare professionals if their health deteriorated.

Some people required repositioning to minimise the risk of developing a pressure ulcer. We saw guidance about how often people should be repositioned in their care records. We looked at the repositioning charts for one person. We saw that the chart was incomplete so it was not clear whether they were being repositioned as often as the service had assessed them as needing. The manager informed us that this person was mobile and that they only required repositioning every four hours. This meant that the guidance in the person's care records was not accurate. We saw that one person had a risk assessment for pressure ulcers. However, there was not a repositioning chart for this person. This increased the likelihood of the person developing a pressure ulcer or the worsening of an existing one.

We saw that the manager had allocated three staff to each of the day shifts. We noted that this was the same amount of staff that were deployed on our previous inspection. We also found that there were no longer any allocated supernumerary hours to the staff member in charge of the shift. The number of people living in the home had only decreased by two people, however, the manager told us that they were admitting more people who were very frail. This meant that an increasing number of people required a high level of support. This demonstrated that the manager had not taken into account our recommendations and reviewed the staffing levels according to people's needs. We observed at particularly busy times where staff were administering people's medicines or making the evening meal that the amount of staff available to support people decreased.

We noted from the staff rotas that there were consistently three staff on during the day shifts. However, we were told by one member of staff that another member of staff had been called in to work on the day of the inspection. They told us this was because they had been "Taken off the floor and [staff member's name] is doing [medicines] so wanted to make sure that everybody was up in good time." This demonstrated that

there were insufficient numbers of staff to support people and attend to managerial duties when they occurred. Another member of staff commented, "[We] could do with more staff but [we] can meet people's needs with the numbers we have." The manager told us that they had recruiting more staff and said, "One in 10 aren't suitable."

We saw from the staff rotas that on one occasion a member of staff worked for 24 hours in order to provide cover for a night shift. This posed a potential risk, for example people's care needs could be compromised due to the staff member being overly tired. We spoke with the member of staff and they confirmed this. Staff we spoke with all felt that there were enough staff to safely support people.

People told us that they received their medicines, but they were not always sure what their medicines were for. One person told us, "There is always somebody about you can ask, I never feel unsafe, the carers give me my tablets and my insulin, I don't know what [the medicines] are for, [staff] would tell me if I asked." Another person we spoke with explained, "The staff are kind and very good to me, they give me my tablets, I just take them, [the staff] see to all that." During our inspection we saw that a person had queried with staff what their medicine was as they did not know what it was for. We observed that staff had a nice approach to people when administering medicines. The staff member explained what the medicines were and asked for consent and whether the person wanted to take them.

We saw that there were safe practices around the administration of insulin. Staff told us that they had training in this and records we looked at confirmed this. We noted that staff recorded the site of injection and monitored and recorded people's blood sugars.

We looked at the personnel files of three members of staff. We saw that appropriate references had been sought and DBS checks had been carried out before staff commenced their employment, apart for one member of staff. One member of staff we spoke with confirmed that they had to provide references and wait for a satisfactory DBS check to be completed before they started work.

Staff we spoke with were able to demonstrate that they had an understanding of safeguarding and what constituted abuse. Staff were able to tell us what procedures they would follow and who they would report their concerns to. Staff told us that they had received training in safeguarding and training records confirmed that most staff had received training in this.

People we spoke with told us that they felt safe living in the home. One person told us, "There are a lot of people around you, if you need help you just shout, the [staff] are on the ball, [the staff] see what is going on." Another person we spoke with explained, "Just being here makes me feel safe, being looked after."

The manager told us that one accident happened recently. We saw that the accident had been recorded in the person's care records. The manager told us that the care system that they use monitors how often people are having accidents and the manager is able to identify any patterns and put in measures to protect people from further occurrences.

Requires Improvement

Is the service effective?

Our findings

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 so that they can 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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us that applications to deprive people of their liberty had been made for all people living in the home apart from two as they were able to make decisions for themselves.

The manager confirmed that these two people had capacity to make decisions for themselves. We asked the manager if the two people were able to get out of the home as it was consistently locked. The manager told us, "We have given them the code but if they forget it then that's up to them." The manager went on to say that they had made a decision not to allow one of the people to leave of their own free will. They told us that they would fall down the steep steps upon leaving the building if they went out. This meant that the manager was making a decision to restrict these two people's movement when they had the capacity to make decisions for themselves.

Staff we spoke with were uncertain if there were people living in the home who needed to be deprived of their liberty.

Staff told us that they had received training in this area and understood the basic principles of the MCA. Staff were able to tell us how they offered people choices and asked people for their consent before taking any action.

We looked at the staff training matrix and saw that some staff had been working at the home for over a year and had not yet received all training relevant to their role. For example, we noted that two members of staff had not received training in safeguarding. We noted that over the past year that Highfield had cared for people who were at the end of their life. In spite of this, only three staff had received training in providing end of life care and they had last received this training over six years ago. Due to the lack of staff trained in this area of care, we could not be sure that all staff had the necessary training to care for people effectively. The manager told us that they had identified gaps in staff training and had booked staff on to the relevant courses.

We spoke with staff about any training they had received and what support they had in order to carry out

their role effectively. We received varied responses from staff. One member of staff told us that they had not received any training or an induction when they started working in the home. Another member of staff we spoke with told us that they had received training relevant to their role. Staff told us that training was delivered by the manager and one member of staff told us that they received refresher training in areas such as safeguarding and moving and handling.

We looked at the staff training and supervision matrix and saw that supervisions and appraisals were not happening on a regular basis. For example, we saw that a number of staff had not received supervision since January 2016. This meant that staff did not have a regular opportunity to discuss their role, any issues or training needs. Supervision is a useful and confidential forum in which the manager can discuss staff's practice and make provisions for any gaps in their skills or knowledge.

We observed lunch being served and noted that there was little consideration given to creating the right environment for an enjoyable mealtime. There were no tablecloths or condiments on the tables. We also noted that there were no menus on the table to remind people of their choice of meal. No choice was offered to people although we did see one person who had a different dessert. People were not engaged in conversation as most staff went and ate their lunch in the lounge. One staff member ate their lunch standing up by the dinner trolley and we observed them pick some food from one of the trolleys which was unhygienic.

We spoke with the cook who told us that they were relatively new to their role and that they were unsure of how the menus were devised. A member of staff we spoke with told us that people were only offered one choice of meal. People were not asked in advance if they wanted it. If people refused their meal then they would be offered something else.

People we spoke with were positive about the food at Highfield. One person told us, "The food is good, I eat everything." Another person we spoke with commented, "I enjoy the food, you have chicken, fish and chips. Things like that." We saw that some people had adapted crockery and cutlery which enabled them to eat their meal independently. We saw that the meal served on the day of our inspection looked appetising and well balanced.

We asked people if they were supported to see other healthcare professionals where necessary. One person we spoke with explained, "I saw the doctor yesterday, I am having treatment for my chest, I visit my optician and someone takes me, the chiropodist I see here." We saw that prompt referrals were made to relevant healthcare professionals where concerns were identified about people's health or wellbeing. We noted from people's care records that any consultations with healthcare professionals were documented and this information was relayed to staff via daily handover notes.

Requires Improvement

Is the service caring?

Our findings

The service was not consistently caring. People's dignity and privacy were not always respected. During our inspection we noted that a person who was receiving palliative care was located in a room which could only be accessed by walking through a large office. This office could also be used by people who were living in the home for a variety of activities. There was an en suite to the person's room and we saw that this was being used by the hairdresser to wash people's hair. We noted that every time the tap was turned on, a loud noise would resonate throughout the adjoining rooms. People then had their hair cut in the adjacent room. There was laughing and joking whilst people were having their hair done. The door to the adjacent room kept banging shut then the hairdresser would open it again. We spoke with the manager about this as it was felt that this was not the most appropriate room for a person who had been assessed as having a high level of dependency. This also did not provide the person in the room with any privacy. We also saw that another person was left wearing a tabard for most of the morning and afternoon. This did not demonstrate that staff knew how to maintain a person's dignity.

During our inspection we heard staff speaking about people's weights in front of people in a communal area. We also saw people's confidential documents outside the small office downstairs where they could have easily been read by anyone. In addition to this, we saw lists with people's names on and their level of mobility displayed in the corridors throughout the home. Another concern we noted was that the main office which was used by staff was located in an activities room. There was a computer in the office which was used by staff to update people's care records. This meant that people's confidentiality was not consistently maintained.

We made several observations throughout the day which demonstrated that staff priorities were misplaced. At lunch time staff ate their meal in the lounge rather than offering people support or taking advantage of the opportunity to socialise with people. People were given their meal on melamine plates. There was no evidence to show why people could not eat off china plates. We saw that one person was distressed at having lost something from their room. They were asking where the item may be but staff were not responding. When we prompted a member of staff, they found the person's item in the office.

We saw two members of staff supporting a person in a hoist. There was no explanation about what was going on and permission had not been sought from the person prior to them being moved. The only interaction we observed was when the person was about to be seated, we heard the staff member say, "There you are, we are putting you down." We also saw that the person had a sticky discharge coming from their eye that staff had not attended to.
These findings constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were positive about the way they were cared for at Highfield. One person we spoke with told us, "I am looked after very well [the staff] are very nice to me." Another person we spoke with commented, "The care is very good, although I don't need much, I have a bath about twice a week and the staff will say 'are you ready for your bath?'."

Requires Improvement

Is the service responsive?

Our findings

People's needs were not consistently responded to. Throughout our inspection we noted that there was not much interaction between people and the staff. We saw that people were often left in the same place all day. When we first arrived at Highfield we saw a person wearing a tabard sitting in the lounge, we noted that the person was in the same position, still wearing the tabard nearly two hours later. We saw that this person was still sitting in the same position in the afternoon. We also saw two people sitting in the dining room for over an hour in the afternoon as they had not been given the choice to be supported away from the dining room after lunch. We noted that one of these people looked restless. Staff had not noticed this as they were putting a delivery away. We saw from people's care records that most people living in the home required support with getting bathed and dressed in the morning. At 10am a person we spoke with told us that they were waiting for a member of staff to help them get up and washed. They were sitting on the end of the bed in darkness.

The manager had purchased a computer based care planning system. People's care records were stored on the computer and staff had a dedicated computer in a large office from which they could access people's records. We noted that people's care plans and risk assessments should be reviewed every month. We were told by that manager that the system would alert staff when people's records required reviewing. We noted that some of people's care records had not been reviewed within the last month.

We noted that people's care plans were not person centred. We saw that a number of stock phrases were used and had been copied and entered into people's care records. For example, we saw from the care records that every person had a care plan for maintaining a healthy nutritional intake. We saw the phrase "eats 100% of her pudding" in all three care records, including males.

We asked staff about the contents of people's care plans and whether they read them regularly. One member of staff we spoke with told us, "I have seen the care plans but I don't have the time to look at them. I do not have computer skills." Another member of staff explained, "I used to look at the care plans but now they are all on the computer, I don't look at them." This meant that there was a risk that staff were not aware of people's most current care needs.

We saw that staff kept daily records of people's physical health and wellbeing. We also saw that a handover sheet was written. This informed staff of what support people required that day and the outcome of any appointments attended that day.

We were told by the manager that they had employed an activities coordinator who went in three times a week. They added that this would increase to five times a week in the coming months. We asked people how they liked to spend their time. One person told us, "I like to join in whatever is going on." Another person explained, I like to get out in the garden and do weeding but would prefer to be weeding in my own garden."

The manager told us that they had not received any complaints in the past 12 months. We saw that guidance on how to make a complaint was pinned to a noticeboard in the main hallway. Staff were able to

tell us how they would support people if they wanted to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

We identified concerns about the day to day running of the service as a result of our previous inspection on 23 and 24 April 2015. The manager was not consistently present and they left the day to day running of the home to the deputy manager. The deputy manager did not have full autonomy and decision making in respect of staff or people living in the home was sometimes delayed, as all decisions needed to be made by the manager. The manager previously relied on the deputy manager and the administrator to email them daily management reports which summarised the events of the day, including any concerns or staffing issues. Since our last inspection, the deputy manager and the administrator had left the service, this meant that the manager did not receive the daily management reports so they did not have a daily overview of the service.

During our inspection 12 October 2016 we found that the manager was still not present full time in the home and they told us that they would spend three days a week at Highfield. They manager told us that they continued to make decisions regarding people's care and treatment. For example, the manager told us that they relied on staff to inform them of any changes in people's heath or wellbeing. They would then arrange an appointment for the person. This meant that there was a continued risk of decisions not being made in a timely manner due to staff not being afforded any autonomy around decision making. This could have a potential impact on how staff can effectively and consistently manage the running of the home in the manager's absence.

It was clear that there was confusion between the staff and management as to who should be taking responsibility as the person in charge in the manager's absence. When we arrived at Highfield and asked to speak with the person in charge, staff did not know who was in charge. One member of staff told us that they had not been officially told who was in charge but one of the senior care assistants would assume responsibility. The member of staff who said that they were in charge had only been working in the home for four weeks and they had not received an induction. This was of concern as the experienced senior member of staff was busy administering medicines for over two hours whilst the staff member who was on probation was left to supervise the day to day running of the home and the other staff. We asked a member of staff how often the manager was in the home and they told us, "They're here more often than not." Another member of staff told us that the manager was there three times a week. The manager told us that they were always available via telephone.

Not one of the six people we spoke with knew who the manager was.

We saw the responses from a staff survey which was conducted this year. The manager told us that staff could remain anonymous and there was a variety of questions which covered all aspects of the service. We noted that some staff had expressed concerns about people's safety on the survey and about other aspects of the running of the service. We asked the manager about what they did in response to these answers. We were told that no action had been taken to address any areas for improvement. This meant that staff views were not taken into account and the manager did not address the concerns that had been raised as a result of the survey.

The service's website states, "To ensure that our high standard of care is maintained, an independent quality assurance system is in place." We looked that the systems that the manager had in place to assess and monitor the quality of the service. We saw that there was no auditing to monitor the environment for any potential risks and no in house medicines audits were being carried out. In addition to this there was no auditing in place to ensure that weekly health and safety checks were being carried out.

There were a lack of systems in place to monitor and assess the quality of the service being delivered. The audits that the manager carried out failed to highlight that people's risk assessments and care plans were not regularly reviewed or updated. This meant that staff were not aware of people's most current support needs. There was also a lack of auditing around environmental risks such as health and safety and fire hazards. During our inspection we observed that a fire door to a linen cupboard was being propped open. We raised this with the staff and when the staff member tried to close the door it was unable to close. We raised this with the manager and they told us that they would ensure that the door would be repaired. We asked to look at the fire risk assessments for the home and the manager was only able to show us a letter from the fire officer's inspection from 2015 and their fire policy.

The manager could only provide us with three audits; a person-centred care audit, nutritional provision audit checklist and a safeguarding check list. We saw from the safeguarding audit which was carried out in June 2016 that the manager had said that a DBS check had been undertaken for all new staff. This was in contrast to our findings when we looked at staff personnel files. The audit failed to pick this up and was therefore ineffective. In the person centred care audit dated July 2016 it asked 'Are the care plans individualised? (Not generic?).' The manager had circled 'yes' on the form. During our inspection we found that people's care plans were generic and did not account for people's individual care needs.

Whilst staff we spoke with told us that they felt that the manager was supportive and that they felt able to raise concerns with them, other staff told us that concerns were not always dealt with. One member of we spoke with told us that the staff team did not always get on. They said that there were often arguments and that concerns had been raised with the manager but no action had been taken.

These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to display the ratings of their inspection on their website, if they have one. We looked on the service's website and noted that the rating from their last inspection in April 2015 was not displayed on their website.

This finding constituted a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the statutory notifications which we had received. We saw that we were notified of events and incidents in a timely manner.

The manager told us that staff meetings were held every three months. We looked at the staff meeting minutes and noted that a staff meeting was held in September 2016. The previous meeting was held in April 2016. One member of staff we spoke with told us that staff meetings took place two to three times a year. This gave staff the opportunity to put forward their suggestions about how the service is run. We saw from the meeting minutes that staff were able to make suggestions with regards to the service and issues such as staff responsibilities and people's care was discussed. The manager told us that prior to each meeting, they would display an agenda on the staff notice board. They told us that staff were invited to add items to the

agenda for discussion. The manager added, "I get very few staff adding to this."

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 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always preserved and personal information was not always treated confidentially. Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed or administered in a safe way and there was no system in place to evaluate practice in this area. Regulation 12(2)(b)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Suitable systems were not in place to monitor and mitigate risks to the welfare of people or to evaluate practice in this area. Feedback about the service was not considered or acted upon. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The most recent rating was not displayed conspicuously on the service's website. Regulation 20A(1)(7)(b)