Sterling Care (Uk) Ltd

Highfield Residential Care Home

Inspection report

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Date of inspection visit:
09 August 2017
10 August 2017

Date of publication:
27 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 9 and 10 August 2017 and was unannounced.

Highfield Residential Care Home provides accommodation for up to 20 people, many of whom are living with dementia. At the time of our inspection 18 people were living in the home.

The registered manager had been in post since January 2012. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager is also the nominated individual. A nominated individual is someone who acts on behalf of the provider. 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 12 October 2016. We found that the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of four regulations including dignity and respect, safe care and treatment, good governance and requirement to display performance assessments.

Following our previous inspection in October 2016, the provider sent us an action plan stating that they would make the required improvements by 30 June 2017.

At this inspection we found that the provider had taken action to meet the requirement of displaying their performance assessment and were therefore no longer in breach of this regulation. However, we still had concerns relating to the safe care and treatment of people, how people were cared for and the governance of the service. The provider had not taken the necessary actions to meet the requirements. We also found that the provider was in breach of four further regulations during our most recent inspection.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The service was not safe. Individual risks to people had not been identified or managed in a safe way. This was because advice given by relevant healthcare professionals was not used to inform risks assessments. People's risk assessments were not reviewed regularly and assessments to determine people's risk of pressure ulcers and malnutrition were not carried out frequently. Where people were at risk of developing a pressure ulcer, they were not always repositioned frequently enough to minimise the risk of developing a pressure ulcer.

We found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's level of dependency was not assessed and therefore staffing levels were not calculated to support people in the safest way possible.

Risks to the environment were not managed appropriately. There was a lack of monitoring around fire safety, electrical safety and the risk of legionella was not mitigated. Health and safety audits failed to identify these risks and were therefore ineffective.

People's medicines were not managed or administered in a safe way. People did not always receive their medicines as prescribed and topical creams and thickener for drinks were not kept secure. Whilst staff had received the necessary training in administering people's insulin, people were not referred for a diabetic review when their blood sugars became unstable. This meant that the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not act in accordance with the Mental Capacity Act 2005. Assessments of people's mental capacity had not been carried out and best interests decisions made for people were not documented.

People were not consistently offered choice about their care and treatment and there was little information about people's preferred way of communicating.

Risks relating to people's nutritional and hydration needs were not managed or mitigated. People did not receive a diet according to their dietary needs. Records of people's food and fluid intake did not accurately reflect what people were consuming. These findings meant that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mealtimes in the home were disorganised and people were not served their food at the same time. People did not always have access to adapted crockery which would enable to them to eat independently.

We found a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not treated with dignity and respect. Staff did not explain to people what they were doing when they were delivering care and the cleanliness of the garments people were wearing or using was not ensured.

Confidential information about people was not always kept in a secure way and documents were left accessible to people living in the home and offices were not always locked.

Staff were not aware of people's care needs and people's care plans did not detail what support people required and how that support should be given. These findings constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of audits in place to monitor and assess the quality of the service. Whilst two audits were taking place regularly these were in the form of basic daily and weekly checks and did not identify shortfalls within the service. The registered manager did not conduct any comprehensive monitoring of the service.

There was no clear leadership of the home and the provider was not at the service full time. The member of staff who was in charge of the home in the registered manager's absence was not given the time to attend to the daily managerial tasks associated with running the service. These findings meant the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always receive training relevant to their role. There were a number of gaps in staff training records and the registered manager did not provide a formal induction for new employees. The registered

manager had taken steps to improve the frequency of supervision for staff.

Not all staff had received up to date training in safeguarding but staff knew the signs of abuse and the procedure they would follow to report any concerns. The registered manager took steps to ensure that suitable staff were employed and carried out appropriate checks before appointing new members of staff.

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 expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Steps were not always taken to manage and mitigate individual risks to people or the environment.

People's medicines were not administrated or managed in a safe way.

People's levels of dependency were not assessed and staffing levels were not sufficient to meet people's needs in a safe way.

Staff understood what constituted abuse and how they would report any concerns.

Is the service effective?

Inadequate

The service was not effective.

The service did not act in accordance with the Mental Capacity Act (MCA) 2005 and MCA assessments were not carried out.

People at risk of malnutrition were not supported to maintain a healthy nutritional intake or referred to relevant healthcare professionals where concerns arose.

Staff did not receive training relevant to their role and there was no formal induction process for new staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not treated in a respectful way and their dignity was not consistently upheld.

People were not consulted about making choices about their care and treatment.

People's independence was not promoted.

Is the service responsive?

Inadequate

The service was not responsive.

There was little interaction between people and the staff.

People's care records were not up to date and assessments were not carried out for people who were looking to live in the home.

People were not supported to maintain their interests or hobbies.

Is the service well-led?

Inadequate

The service was not well led.

There were few measures in place to monitor and assess the quality of service being delivered. Those that were in place were ineffective.

There was a lack of visible leadership in the home.

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 9 and 10 August 2017 and was unannounced. It was carried out by two inspectors.

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. Before the inspection we received feedback from the local safeguarding team and the commissioners.

During this inspection we spoke with two people who were living in the home and one visitor. We also spoke with four members of staff, the registered manager who was also the provider and the cook. We looked in detail at the care records for six 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 quality monitoring reports.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection on 12 October 2016 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always being given their medicines as prescribed and there was a lack of guidance available to staff on managing people's medicines in a safe and consistent way.

We found during this inspection on 9 and 10 August that there were still concerns around the safe administration and management of people's medicines. We concluded that the provider was still in breach of this regulation.

Following our inspection on 12 October 2016, an action plan was submitted by the provider which detailed how the service would meet the legal requirements. They told us that this would be completed by 30 June 2017. The provider stated in the action plan that regular audits of people's medicines would be carried out the provider.

We saw that audits of people's medicines were being carried out by a member of staff but these audits did not identify that people did not always get their medicines as prescribed. For example, one person was prescribed a transdermal patch to manage their pain. This patch should have been changed every 72 hours. We saw from the patch application record that the person's patch had not been changed for six days. This meant that there was a risk that the person suffered preventable pain due to the delay in having their pain medication. We also noted from this record that staff did not always record where they had applied the patch. It is good practice to indicate where the patch was placed on the person's body as the application site of the patch should be rotated.

On the first day of our inspection, we saw the member of staff who was administering people's medicines ask another member of staff to sign to say that they had witnessed a high risk medicine being administered. The member of staff who was asked to sign told us that they had not witnessed the person being given their medicine and that staff will sometimes administer controlled medicines and get other staff member to sign retrospectively. The National Institute of Clinical Excellence's guidelines on the safe use and management of certain medicines associated with high risk states that the name and signature or initials of any witness to the administration of controlled drugs should be recorded appropriately. The registered manager's policy on medicines also stated that two staff members should be present when these medicines were being administered. This meant that staff did not always administer people their medicines in a safe way, according to national guidance or the registered provider's policy.

We found that there were a number of other concerns relating to the administration of people's medicines. We looked at five people's medicine administration record (MAR) charts and saw from these records that people were not receiving their medicines as prescribed. One person was prescribed a medicine four times a day but we saw from their MAR chart that they were only receiving this three times a day. When we asked staff about this they told us that they did not have their evening dose as they went to bed early. We did not see that the person's GP had been consulted regarding this. We saw that a third person's medicine, that was

being administered, was not entered on to their MAR chart. It stated on the box that the medicine should be taken four times a day.

There were no PRN protocols in place. A PRN medicine is a medicine that people are prescribed to take as and when required, for example paracetamol. It is good practice for staff to know the circumstances why the PRN medicine has been prescribed, when to administer it and what the medicine is for. It is also good practice for staff to record this information. This allows for staff to monitor and review people's ongoing health needs and make a referral to a healthcare professional if needed. There was therefore a risk that medicines were administered inappropriately.

Some people were prescribed topical medicines. We looked at three people's cream application records. One person did not have their creams applied for six days when they should be applied daily according to their records. We saw from another person's record that they did not have their cream applied according to the guidance in their care plan. A third person had not had their cream applied for three days. There were no details on the cream charts to inform staff where the cream should be applied and how often it should be applied. Therefore there was a risk that people's skin was not appropriately protected and cared for, and skin conditions were not treated appropriately. People's topical medicines were stored in their rooms. A lockable cabinet was provided but we found that three people's medicine cabinets in their rooms were unlocked and they all contained prescribed creams.

Staff monitored people's blood glucose levels, this was to ensure that people who were living with diabetes maintained a stable blood sugar level. We looked at two people's blood sugar monitoring forms. We saw from one person's record that their blood sugar levels varied greatly. It stated in their care plan what their normal blood sugar readings were. We noted that their blood sugar was only within this range six times over the past month. We saw from another person's record that their blood sugar levels also varied greatly. There was nothing in their care plan to detail what their normal range was. Neither person had been referred to a healthcare professional regarding the fluctuations in their blood sugar levels. This demonstrated to us that the service did not respond appropriately to increased risk to people associated with their health conditions.

Staff did not mitigate risks associated with people developing pressure ulcers. Some people were at high risk of developing pressure ulcers. We saw from one person's care records that they were at risk of developing a pressure ulcer. We noted that they were sat on a pressure relieving cushion. This was placed on a chair that was unsuitable as they sat up very high, and were at risk of falling from the chair. Some people had pressure relieving mattresses and we noted that one was not inflated properly.

We noted that for two people there were repositioning charts in place. These charts were used by staff to record when they had supported a person to change position. We saw from one person's care plan that they should be supported to change position every three to four hours. We noted from their repositioning chart that they were sometimes not supported to move for five or six hours. It was unclear how often the second person required repositioning as there was no guidance in their care records about this. Both repositioning charts did not detail the frequency of repositioning. We noted that there were two other people who required two staff to support them with moving in bed but there were no repositioning charts for these people. We saw from their care records that they were assessed as being at risk of developing a pressure ulcer.

Risk assessments for people were not regularly reviewed and they did not contain the most up to date information about people's individual risks. For example, we saw that one person was supported by two staff to stand with a stand aid. Their risk assessment around mobilisation stated that they could mobilise

independently. We found that two tins of thickener on the top of the fridge in the kitchen and a further five in an unlocked larder. We found that the sluice room was unlocked and there was a bottle of disinfectant in there. There were no risk assessments about the safe storage of items that could potentially cause harm to people. There was therefore a risk that people who were living with dementia could accidentally ingest or misuse a dangerous substance, which could have severe consequences.

Some people were at high risk of falls and whilst staff recorded the fall in people's care records, the registered manager did not collate information relating to people's falls. The last falls audit was carried out in April 2016. Therefore they did not identify patterns or trends in incidents, or take any action to further mitigate risks to people where needed.

We saw that a number of people in the lounge had tables in front of them. We saw that one person was restless and was trying to get up. The person required two people to support them with mobilising. We saw that a member of staff came along and pushed the table back in front of them. This was a form of restrain that would prevent the person from moving about. We saw from their care record that they required staff assistance at all times with mobilising. This meant that the person was at risk of falling if they continued to try and get up from their chair. Staff were not managing this risk appropriately.

Risks within the environment were not managed and mitigated. We noted that a fire escape route was blocked by old furniture and a fire door to the laundry was propped open. Fire audits had not been carried out. There were no measures in place to manage the risks relating to the prevention of Legionnaire's Disease. There was a risk assessment in place which stated that regular checks of the water system should be carried out but water temperatures were not tested and the last time an external contractor had visited the home to check the water system was in 2015. Electrical equipment was not safety tested. The registered manager told us that they carried out testing on electrical equipment but they were unable to show us any records of the items tested and when this happened. We saw that an electrical fan had a sticker on it stating that it had last been tested in 2011. The Health and Safety Executive states that portable appliances should be tested at regular intervals to ensure that they are safe to use.

Infection control procedures were not always put into practice. During the morning of the first day of our inspection we saw that two members of staff were changing soiled beds. They were not wearing any disposable aprons. They were carrying the soiled bedding next to their uniform. We later observed the same two staff members wearing cloth aprons from the kitchen whist serving people their food. This could result in cross contamination. We observed a member of staff administering people's medicines using poor hygiene practices and unsafe management of medicines. We saw that they took a person's medicine to them in their hand and then put the tablets directly into people's mouths. We saw this on two occasions and on both occasions we saw that the staff member was not wearing any gloves. This is unsafe practice.

As a consequence of these findings the provider was still in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the people we spoke with told us that there were not enough staff to meet their needs. They told us that they had once waited for half an hour for staff to answer their call bell. They added that they sometimes had to bang on the floor with their mobility aid to get staff's attention when they required assistance. All of the staff we spoke with told us that they could do with more staff. The visitor we spoke with told us, "There's sometimes no staff in the main dining room or living room." Throughout our inspection we noted that there was not always a staff presence when there were people in the communal areas. We saw that people in the lounge and dining room did not have access to a call bell so could not summon staff assistance quickly.

There were a number of people living in the home who required two staff to assist them to mobilise. Staff told us that sometimes this meant that people had to wait before they were attended to if staff were busy with another person. During both days of our inspection we saw that it took over two hours for people's medicines to be given. This left two care staff to attend to the 18 people living in the home at the time of the inspection.

The registered manager told us that they did not calculate people's levels of dependency and there was no system to review people's dependency. Therefore, they were not able to ascertain how many staff they required to support people effectively.

We looked at the past four weeks of the staff rota and saw that there were six occasions where there was only one member of staff working a night shift. On one occasion there were only two staff members working a late shift when there should be three staff on duty. The registered manager told us that they were trying to recruit more staff and they sometimes had agency staff working in the home to cover the shortfalls. They told us that they requested the same staff to ensure as much continuity of care as possible for people.

As a consequence of these findings the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that they had received training in safeguarding adults. The training records showed that only four staff had in date training for this. However, the staff we spoke with knew what constituted abuse and who they would contact if they had any concerns.

We looked at the personnel records of three members of staff and noted that appropriate references had been sought and a satisfactory police check had been obtained before they started working at Highfield.

Inadequate

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 registered manager told us that applications to deprive people of their liberty had been made for 13 people who lived in the home. We were unable to find mental capacity assessments for all of the people's care records we looked at. There were no records of best interests decisions for people. Appropriate people were not consulted about actions staff took when making decisions for people, so we could not be assured that decisions were always made in people's best interests. We noted that one person had tried to leave the home the day before our inspection and they were bought back by staff. This was because staff did not feel that they were safe to go out alone. However, a DoLS had not been submitted for this person or a mental capacity assessment carried out.

People were not always asked for their consent before staff did anything for them. We saw that one person was given their medicines when they shook their head in response to being asked if they wanted them. There was nothing in the person's care records to show that the person's capacity to make the decision to refuse their medicines had been assessed. Nor was there a best interests decision setting out that the person should continue to be given their medicines even when they refused to take them.

Staff we spoke with did not have a good understanding of the MCA and when we asked one member of staff what the main principles of the MCA were they commented, "Pass." Three members of staff we spoke with did not know how many people were being deprived of their liberty. Because of the lack of staff knowledge about the principles of the MCA and DoLS, there was a significant risk that people were being restricted more than was necessary to provide safe care. There was also a risk that people were not supported in making their own decisions wherever possible.

These findings constituted a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional and hydration needs were not always met. We saw that one person was being given a pureed diet as there was advice from the speech and language therapy (SALT) team which recommended they have a soft diet. A soft diet means that food is cooked so it is soft in texture and easier to chew. Three staff we spoke with told us that the person was on a pureed diet where food is blended to form a liquid. We

saw from another person's SALT assessment that they were at risk of choking so they needed to be sat at upright whilst drinking and for thirty minutes afterwards. On the second day of our inspection we saw that the person had slid down in their chair and had a drink beside them. We advised the registered manager that they should be sat up due to the risk of choking. They explained, "They'll just slide down again." Action was not taken to mitigate the immediate risk to the person.

We saw from another person's care records that they had been assessed by SALT and the advice was that they should be given fortified food. They should also eat small and frequent meals. There was nothing in their care plan to reflect this advice. We observed that they were not given small meals at lunchtime. We also looked at their food and fluid chart as in their care records it stated that they should be encouraged to drink at least one and a half litres of fluid per day. We saw that the total amounts of fluid were not recorded and the amount of food they had eaten was not recorded; only the type of meal they had. We found that this was the case for all people who required their food and fluid to be monitored. This meant that staff did not know if people were eating or drinking enough.

We saw from one person's care record that they were at risk of not eating enough. 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 over a year. This meant that there may be a delay in them receiving the most appropriate care if their health deteriorated.

We spoke with a member of kitchen staff about people's nutritional needs and they told us that staff wrote notes about people's diets and stuck them on the fridge. Some of the information that they had was not up to date and we could not see the information that one person required a fortified diet.

We asked people what they thought of the food at Highfield, and we received mixed feedback. One person told us, "The food is perfect." Another person explained, "When I first came here I said I was a vegetarian. Got very dull meals. So I decided to start to eat meat again."

We observed during the lunchtime meal that people's needs were not fully met. For example, on the first day of our inspection that four people sat in the lounge did not have a drink. In one person's care plan it stated that they should have small sips of liquid whilst eating, and they were unable to do this.

We saw that there was a chair for taking people's weights. The provider told us that the chair had not been calibrated in the three and a half years that they had it. This meant that when people were weighed an accurate reading may not be given.

These findings constituted a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people what they thought of the food at Highfield, and we received mixed feedback. One person told us, "The food is perfect." Another person explained, "When I first came here I said I was a vegetarian. Got very dull meals. So I decided to start to eat meat again."

The registered manager told us that they did not have a formal induction process for staff. They explained, "Usually a senior shows [new staff] around to show them what is where." They went on to say that most of the staff that they employed had an NVQ in care so they already had an understanding of how to care for people. Staff we spoke with told us that they had regular supervisions and records we looked at confirmed

that staff were receiving regular supervisions and appraisals.

We looked at the training matrix for staff and noted that there were a number of gaps. For example, only 13% of staff had received training in infection prevention and control and 27% of staff had received training in health and safety. There were also staff who had not received up to date training in first aid and fire safety. Staff did not have a good understanding of people's medicines. When we asked a member of staff what the pain patch was for, they told us that they did not know.

The support that people received to access relevant healthcare professionals varied. We saw that people were not always referred to receive care from a diabetes specialist when their blood sugars became unstable. Another person told us that they did not wear their hearing aids because their glasses did not sit properly when they had their hearing aids in. They explained that staff had not discussed the possibility of getting smaller hearing aids which would fit inside the ear.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 12 October 2016 we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's dignity was not always preserved and people's personal information was not always treated confidentially.

Following our inspection on 12 October 2016 the provider submitted an action plan which detailed how these concerns would be addressed in order to meet the legal requirements. They told us that this would be completed by 30 June 2017. The action plan stated that the provider and the senior member of staff in charge of the shift would implement changes in this area. We concluded that the provider was still in breach of this regulation.

People were not always treated in a caring way and staff lacked compassion. One person told us, "The staff are not sympathetic." They went on to say that when staff once answered their call bell they told them, "We were just about to go on our break." Another person told us that they did not always feel listened to when they were upset. We saw that when people were hoisted that staff did not always seek consent or explain to people what they were doing. Staff did not always ensure people's comfort as much as possible. For example, we saw one person being hoisted in the lounge, and saw that when staff tried to put the person's reclining chair upright, it kept catching on a table. When the person was in their wheelchair, a member of staff pulled them back without the footplates on and the person's feet dragged along the floor for a few feet. Staff then took the person out of the lounge without any explanation of where they were going.

People's privacy and dignity was not always upheld. Staff did not always ensure that people had clean aprons or blankets. We saw that one person had a soiled tabard on for most of the first day of our inspection. A second person had a soiled patchwork blanket over their lap. People's personal appearance was not always taken care of. We saw that one person had dirty fingernails and overgrown toe nails. We saw that one person was being supported by a member of staff to the bathroom. The staff member was walking in front of them and had hold of the person's forearm whilst they were walking with them. This person was not supported in a dignified or caring way to mobilise.

Staff did not always speak about people in a respectful way. We heard one member of staff say at lunchtime, "Those are the [puddings] for the diabetics are they?" We also noted that people's notes were not always written in a respectful manner. We saw in one person's care records that there was an entry which stated that the person was 'lying on right side with their bum in the air.'

We saw that one person was visited by a Church member and they were having a small service in the dining room. Also at the table was a person who was asleep. We did not see that they were offered a private place in which to practice their religion.

People were not supported to eat their meals in a dignified manner. We observed that a member of staff sat on the arm of a chair of one person whilst supporting another person to eat. The member of staff got up five times throughout the meal and left the person. Every time they sat back down they did not ask the person

whose chair they were sharing if was okay to sit there. On one occasion when the person being supported to eat was left alone, another member of staff came in, leant over them and gave them a spoonful of food. Another person who was sat in the lounge was finding it difficult to eat with an adapted spoon. We later heard a member of staff shout, "She can't use this one, is that the left handed one?" It transpired that the person was given an adapted spoon for left handed people when they were right handed. On the second day of our inspection we saw that a member of staff was leaning towards a person and supporting them with their food. We noted that there was very little interaction between staff and the people they were supporting. People were all served their meals at different times. This meant that some people were sat waiting for their meal when others had nearly finished theirs. For people living with dementia, this could be a confusing situation. For example, one person was being supported with their meal and we saw that one person next to them had their dessert bowl placed on the plate they had their lunch from. They were still trying to eat from the plate even though there was only some gravy on it.

People's belongings were not treated in a respectful way. On the first day of our inspection we saw people's clothes were being dried on a shower rail above a bath that contained a bucket of used continence pads. We also saw that a cup which had been used to keep a person's dentures in was left with the sterilising solution in and there was debris in the solution.

People's confidential information was not always stored securely. On the first day of our inspection we saw that the high risk medicines book was left open outside the down stairs office. There was also a diary that contained information about people's confidential appointments. There were also two files that contained details about people's personal care. The downstairs office which contained paper copies of people's care files was left unlocked and the door was often propped open despite a notice on the door stating the door should be kept locked. People's care records were also kept on a computer based system. This was located in a large office that some people would sometimes sit in. By one of the computers, was a pad with a note stating, '[Person's name], no pad on.' This meant that people's confidentiality was not always maintained.

Whilst staff were able to tell us how they offered people choice, we did not see that people were always able to make decisions about their day to day care and treatment. One person we spoke with explained, "I like to stay in my room, but the staff keep asking me to go downstairs saying it'll be better for me." People did not always have a choice of where they wanted to spend their time. We saw that most people were in the same place all day and staff did not ask people if they were where they wanted to be.

People's independence was not promoted. One person we spoke with told us that they needed a double handed cup as they found it hard to grip a one handled one. They explained, "Sometimes staff forget this." During one lunchtime we saw that a person was managing to eat independently, a member of staff came along, took the spoon from them and took over. This was done without consent and removed the person's independence.

These findings constituted a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people were not always treated in a caring and respectful manner we did see some examples of staff offering people choice. For example, we saw one member of staff explaining to one person what was for lunch and if they wanted any condiments with their meal. We saw the same staff member compliment a person after they had been to the hairdresser.

Inadequate

Is the service responsive?

Our findings

People's needs were not consistently responded to. Throughout our inspection we noted that there was little interaction between the staff and the people living in the home. The visitor we spoke with told us that there used to be an activities coordinator who would engage people in a variety of hobbies but they no longer worked in the service there was little for people to do. We saw on the first day of our inspection that three staff sat in the dining room talking amongst themselves rather than interacting with the people who had sat there most of the morning. One member of staff attempted to make conversation with one person before picking up a magazine to read it. During the afternoon we observed that five staff members were sat eating cake and chatting to each other.

People were left in the same place for much of the day and often staff were not present in the most frequented communal areas such as the lounge or dining room. We saw that staff walked through these areas and did not always acknowledge people. During the first day of our inspection we noted that one person was assisted to use the toilet during the morning and afternoon. Three other people who were sat in the lounge for the duration of our first day also required support with attending to their personal hygiene. We looked at the personal care records for all four people we observed in the lounge and they confirmed that the three other people we observed had to wait for over 10 hours before they were supported with their personal care needs. We saw from the personal care records that all three people required personal care by the time they were assisted in the evening.

Staff we spoke with were not clear about people's care needs. For example, staff were unable to tell us about people's needs such as how many people were being deprived of their liberty and who required support with repositioning or food and fluid monitoring.

People's care plans and risk assessments gave little detail about what support people required and how that support was to be given. For example, in one person's risk assessment for pressure care it stated, 'Staff to make positional changes regularly if unable to do so independently.' This did not provide guidance to staff on how to support the person, or how often, or why they required it. The service used a computerised system to document people's care needs. The content generated by the system had not been sufficiently personalised to reflect people's individual needs. For example, three people's communication care plans were duplicated and gave very little information about how to promote choice and communicate with people according to their individual needs.

There was a form on the computer system where people's preferences and dislikes could be recorded. We saw that this had not been completed for three people.

People's care records were not regularly reviewed or updated to reflect their current care needs. A member of staff told us that the registered manager arranged to meet with people and their family to review their care. We noted that that the registered manager did carry out the reviews of people's care plans and risk assessments via the computerised system but on some of the dates the registered manager was not present at the home. Therefore we were not assured that the reviews included people and their families. Some

people were assigned keyworkers, who were normally senior staff who were responsible for that person's care and the updating of care records. The registered manager told us that they did not always carry out assessments when they had received a referral for Highfield. They told us that they asked for information about the person from the referring professional and make their decision from there. They added, "You don't get a full picture of someone in half an hour, they can change when they get here." However, without a full pre-assessment we were not assured how the service was able to ascertain whether or not they were able to meet people's needs.

Staff told us that they did not always have time to read people's care plans. One member of staff explained that not all of the staff were computer literate so were unable to access the computerised system to update or review people's care records.

People did not always have access to their money. A member of staff explained, "The petty cash for the home is kept in the manager's office and that's locked when they're not here." People's money was also kept in the manager's office and the member of staff we spoke with about this told us that sometimes staff had to buy things for people or the home and claim the money back. Staff sometimes contacted people's relatives if a person needed to purchase something.

These findings constituted a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure in place and a copy of this was on a notice board in the hallway. The registered manager told us that they had not received complaints, only compliments. We looked at several cards from people's families who complemented the care given by the staff at Highfield.

Inadequate

Is the service well-led?

Our findings

We found during our inspection on 12 October 2016 that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to implement suitable systems to monitor and mitigate risks to the welfare of people or evaluate practice in this area. Feedback about the service was not considered or acted upon. They told us that this would be completed by 30 June 2017. The action plan stated that additional quality management systems would be put in place and additional risk assessments would be carried out.

We found during this inspection on 9 and 10 August that there were still concerns around the lack of effective quality monitoring systems in place to monitor and assess the safety of people who lived in Highfield as well as the quality of service being delivered. We concluded that the provider was still in breach of this regulation.

There were two audits carried out by the administrator of the home and these were ineffective as they did not identify shortfalls in the areas they were assessing. For example, the medicine audits carried out looked at whether all medicines had been given at appropriate times but failed to identify that one person was continuously missing one of their medicines in the evenings. The health and safety audit did not identify that a fire escape route behind the home was inaccessible. These audits were carried out on a weekly and daily basis and there was no comprehensive monitoring carried out by the provider.

There were no audits in place to monitor the quality of people's care records or staff training. This meant that people's care plans and risk assessments were not current and gaps within staff training had not been identified and acted upon.

The provider failed to maintain an oversight of the service in general and did not monitor and assess risks within the environment. Whilst the provider had policies and procedures in place which dictated when servicing should be carried out on equipment and utilities, they did not carry out these duties. This meant that people's safety was compromised as well as that of the staff working in the home.

At our last inspection on 12 October 2016 we highlighted concerns that that there was no visible leadership at Highfield. This was because the registered manager was not based at the home full time. On the first day of our inspection we were told by a member of staff that the provider had not been in for a week. We looked at the signing in book and saw that the registered manager was sometimes not at the home for 12 days at a time. We looked at the most recent staff meeting minutes which were taken in July 2017. The registered manager mentioned that day staff and night staff complained about each other and that there was no management between the team. A member of staff suggested that there could be a head figure in place every day who staff could go to, other staff members agreed with this. This demonstrated that there was a lack of visible leadership within the home. A visitor we spoke with told us that they often spoke with senior members of staff rather than the registered manager.

Not all staff showed awareness of staff employed in other roles. For example, there was an activities

coordinator who worked three days at the service but they had left almost two months prior to our inspection. We noted that they were still listed on the rota and two staff members told us that they were still in post and informed us of when they would next be in.

There were a number of concerns about how staff supported people living with dementia. We were informed by one member of staff that sometimes people's relatives were called when a person became distressed. The registered manager informed us that they delivered training in supporting people with dementia. We saw from that minutes of the staff meeting held in July 2017 that staff had asked for advice about how they should manage behaviour that challenged. The registered manager informed staff that 'with dementia, people can change with their brainwaves. We have to be aware and approach, retreat and go back again.' We could not be satisfied that registered manager was fully aware of the training required by staff to support people living with dementia effectively.

The provider did not have a good oversight of the service and how staff delivered care to people in a way that would meet their individual care needs. They had failed to identify that staff did not treat people in a caring and kind manner. Staffs' competency in their role was not observed and staff would take their breaks at the same time meaning that people were left unattended at times.

Staff we spoke with told us that a senior member of staff would take responsibility of the home in the registered manager's absence. They added that they were not allocated supernumerary hours so the day to day managerial tasks associated with running a care service could be attended to.

As a consequence of these findings the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 12 October 2016 we found that there was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to display their inspection rating clearly on their website. We checked the website prior to our most recent inspection and found that the provider had taken action to comply with the regulation. They are no longer in breach of this regulation.

Since our inspection on 12 October 2016, the provider had employed an administrator. They were able to attend to some office based tasks which allowed care staff to spend more time fulfilling their duties. Care staff also sent a daily e-mail to the provider to keep them of important events that occurred within the home. In addition to this, the provider informed us that they had appointed a deputy manager who was due to commence in their role the week after our inspection.

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 People's treatment was not personalised in order to meet their needs. People's care was not reviewed and people's preferences for their care or treatment were not documented. Regulation 9 (1)(2)(3)(a)(b)(c)(d)(e)

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 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were not carried out and staff did not act in accordance to the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to meet people's neds. There was no system in place to monitor and assess the levels of staff needed to support people in a safe way. Regulation 18 (1)

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 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. Individual risks to people's health and welfare were not managed and mitigated. Environmental risks were not adequately monitored. Regulation 12(1)(2)(a)(b)(f)(g)

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Risks relating to people's nutritional and hydration needs were not managed. People were not supported to maintain a healthy nutritional intake according to their dietary needs or preferences. Regulation 14(1)(2)(a)(b)(4)(a)(c)(d)

The enforcement action we took:

Notice of Proposal

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, assess and improve the quality and safety of the service. Accurate and complete records were not maintained in respect of each person who used the service. Regulation 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

Notice of Proposal