Sunplee Ltd

Highbarrow Residential 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 15 August 2017 and was unannounced. At the last inspection on 8 December 2015, the service was rated as Good overall, however we had asked the provider to ensure medicine stocks were accurately recorded. At this inspection we found the required improvements had been made, but we found other concerns with the management of medicines. We also found risks associated with people's safety and wellbeing were not always managed safely.

Highbarrow Residential Home provides accommodation for up to 22 people who require accommodation and or personal care. At the time of our inspection, the home was fully occupied. Some people at the home were living with dementia. There was a registered manager at the service. 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.

Improvements were needed to the management of medicines to ensure staff took a consistent approach when administering medicines prescribed on a when required basis and that people's records were accurately maintained. The provider did not have effective systems to ensure risks to people were effectively assessed, monitored and reviewed. Improvements were needed to ensure the registered manager and provider's checks were consistently effective in identifying shortfalls and were driving improvements. The registered manager did not always act in accordance with their registration and notify us of important events that occurred in the service.

Staff sought people's consent before supporting them. However, improvements were needed where people lacked the capacity to make certain decisions for themselves to demonstrate that their rights were being upheld.

The daily routine at the home did not always promote personalised care that was responsive to people's needs. Improvements were needed to ensure people were always able to take part in activities and social events that promoted their wellbeing and social inclusion.

There were sufficient, suitably recruited staff to meet people's needs. Staff were trained and supported to provide people's care effectively. People had sufficient amounts to eat and drink and accessed the support of other health professionals when needed.

Staff had caring relationships with people, promoted people's privacy and dignity and encouraged them to maintain their independence. People were encouraged to keep in contact with family and friends and visitors were able to visit without restriction.

There was a positive, inclusive atmosphere at the home. People and their relatives felt able to raise concerns

and complaints. People's views were sought in the planning of the service, but changes made were not always monitored to ensure they were effective. Staff felt supported by the registered manager and provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The 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.

Risks associated with people's safety and wellbeing were not always effectively assessed and managed. Medicines were not always managed safely. Staff understood their responsibilities to keep people safe from abuse. There were sufficient, suitably recruited staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff understood their responsibilities to support people to make their own decisions. However, where people lacked the capacity to make certain decisions, improvements were needed to ensure the provider demonstrated they were consistently meeting the legal requirements. Staff were trained and supported to provide people's care effectively. People had sufficient amounts to eat and drink and accessed the support of other health professionals when needed.

Is the service caring?

Good

The service was caring.

Staff had caring relationships with people and respected their privacy and dignity. People were encouraged to remain as independent as possible. People were supported to maintain important relationships with family and friends who felt involved and were kept informed of any changes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The daily routine at the home was not always flexible to ensure people received care and support that was responsive to their individual needs. The provider needed to improve activities and social events at the home to ensure they consistently met people's preferences and promoted their wellbeing. People and

their relatives felt able to raise concerns and complaints and there was a procedure in place to ensure they were responded to.

Is the service well-led?

Requires Improvement

The registered manager did not always notify us of important events that occurred in the service, as required by their registration with us. The provider's systems and processes did not always ensure that risks to people were effectively managed. Improvements were needed to ensure the provider's quality assurance systems were consistently effective in identifying shortfalls and bringing about improvements. People's views were sought on the service but changes made were not always monitored to ensure they were effective. Staff felt supported by the registered manager and provider.

Highbarrow Residential 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 the 15 August 2017 and was unannounced. The inspection team consisted of one inspector 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.

We reviewed the information we held about the service and provider including notifications they had sent to us about significant events at the home. Prior to the inspection, the provider had 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. We used this information to plan our inspection.

We spoke with six people who lived at the home and seven relatives. We also spoke with four members of the care staff, the registered manager and a visiting professional. We spent time in the communal areas observing how the staff interacted with the people who used the service. Some of the people living in the home were unable to speak with us in any detail about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We did this to gain views about the care and to ensure that the required standards were being met.

We looked at the care records for five people to see if they accurately reflected the care people received. We

also looked at records relating to the management of the home including quality checks and staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

We found some concerns with the management of medicines. We saw that one person received anticoagulant medicine, to prevent blood clots. The provider had not ensured that staff administering the medicines had the information they needed to administer the medicine as prescribed. For example, there was no Anticoagulation Record book, or 'yellow book'. This records the blood tests which determine the dosage needed and the date of any subsequent tests to review the dose. In addition, the medicine administration records (MAR) should identify the actual dose administered on each occasion that the dose is administered. We found that staff were administering from a handwritten dosage record, dated June 2017. The member of staff administering medicines told me they had not been able to obtain the yellow book from the GP and the dosage regime had been given to them over the telephone. We checked the MAR and saw that the dose administered on each occasion had not been recorded and the member of staff was not able to show us that the MAR tallied with the stock held for the person. This meant we could not be sure the person had received their medicine as prescribed. We brought this to the attention of the registered manager who contacted the GP surgery to obtain the dosage information to ensure the person was safely supported. Following our inspection visit, the provider has introduced new documentation to address the concerns identified and assure us that staff have the information they need to administer this person's medicines as prescribed. As these changes have just been implemented, this needs a period of time to become embedded. We will follow this up at our next inspection.

Where people were prescribed medicine to manage the risks associated with their behaviour, staff did not have clear guidance on when they should be used. For example one person was given their as and when required medicine on an almost daily basis for over two weeks. The registered manager showed us notes of a meeting with the CPN which recommended the use of the medicine. However, there was no guidance for staff on when the medicine should be used and no care plan in place to guide staff on any distraction techniques to use before administering the medicine. We saw that there was a generic policy on the use of these medicines which recommended the development of an individual plan for each person. However, no individual medicine plans had been developed for people who had been prescribed these medicines, or any individual behaviour plans to guide staff on strategies to use before administering the medicines. This showed us there were no clear systems in place to ensure that people's behaviour would not be controlled excessively by medicines.

Risks to people's safety and wellbeing were not always effectively assessed and managed. We saw that when people presented with behaviour that may challenge themselves and others, risk assessments were not always completed. We spent time observing people in a communal area and saw that one person became unsettled when they returned from an outing with their relative. A member of staff was supporting them on a one-to-one basis, trying to engage them in various diversionary activities, with limited success. At times, the person became increasingly agitated and began raising their voice. Other staff became involved to try and support the person to settle, without success and we saw that this was having an unsettling impact on other people in the home. Staff and the registered manager told us the person's behaviour had escalated over the past few weeks and they were liaising with the community psychiatric nurse (CPN) and

GP to monitor their behaviour. However, there was no risk assessment or care plan in place to guide staff on how to respond when the behaviours occurred. This meant the person's care and treatment was not consistently planned or delivered in a way that ensured their safety and wellbeing.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed medicines being administered and saw that the member of staff spent time with people and checked to make sure they had taken the medicine before leaving them. Staff had received medicines training and had their competence checked periodically by the registered manager. We saw that medicines were stored and disposed of safely in line with the legal requirements.

Staff had received safeguarding training and understood their responsibilities to protect people from the risk of abuse. They were able to identify the different types of abuse and were clear on how to report any concerns. Staff were confident the registered manager would take action if they raised any concerns with them. Discussions with the registered manager showed us that they were aware of their responsibilities to report any concerns to the local safeguarding team for investigation. However, we were aware that they had not notified us of a recent safeguarding concern which had been referred to the local safeguarding team by another professional. We saw they had investigated the incident but could not explain why they had overlooked notifying us. This enables us to check that appropriate action has been taken. We have referred to this in the well led section of the report.

People and their relatives told us the staff were busy and as a result, were not able to spend much time with people individually. However, people had no concerns about having to wait for any length of time for assistance. One person said, "They could do with a few more staff as they are sometimes rushed off their feet and don't really have time to sit and talk, but having said that, they come fairly quickly when I call. I need someone to take me to the bathroom – it's less than two minutes usually. At night I have a commode right next to my bed but they are there as soon as my feet are on the mat to help me". A relative told us, "I imagine you could say there are never enough staff but there is always a carer in the main lounge and they do interact with the residents – they don't just sit doing paperwork". We saw that there were staff available to respond when people required assistance and call bells were answered quickly. We saw that the member of staff who was in the lounge engaged with people on a one-to-one basis whenever they could, whilst checking that everyone else was safe. For example, a member of staff talked with people about the music and their favourite songs and started them singing, which prompted others to join in. We saw that staffing levels were based on people's dependency levels and were kept under review. This showed us the provider had systems in place to ensure there were sufficient staff to meet people's needs at all times.

Staff told us and records confirmed that the provider carried out recruitment checks which included requesting and checking references and carrying out checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. This showed us the provider followed procedures to ensure staff were suitable to work in a caring environment which minimised risks to people's safety.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospital care called the Deprivation of Liberty Safeguards (DoLS).

We found that the provider was not consistently following the requirements of the MCA. We saw that mental capacity assessments had been carried out to determine whether people were able to make decisions about their safety to leave the home. For example, to determine if a DoLS application was required, and we saw applications had been submitted where needed. However, we found that assessments were not always carried out for other decisions and some people's care plans contained contradictory information relating to their capacity to consent to their care. For example, one person had a sensor mat to alert staff that they had got up from their chair when they were in the communal lounge. A DoLS application had been made for this person which showed that they lacked the capacity to make some decisions. However, there was no information to show that the decision to have the sensor met had been made in their best interests or if they had the capacity to give their consent. This meant we could not be assured that people's rights were consistently upheld.

We recommend that the provider seeks advice on best practice, to assess people's capacity in relation to specific decisions for people living at the home.

Staff had received training in MCA and DoLS and demonstrated an understanding of the legislation. One member of staff told us, "It's important to presume that people have capacity; just because they have dementia doesn't mean they can't make decisions. We always give people choices and offer visual clues to help them decide on things, for example I will show them different outfits to help them decide what to wear". This showed us staff understood their responsibilities to support people to make their own decisions as much as possible.

People told us they had sufficient amounts to eat and drink but were not always offered a choice. One person said, "The food is good but no choice. You don't know what it is until it comes. If you don't like what they bring you I suppose they would find you something else, make you a sandwich or something". Another person felt the quality of the food varied, "It can be very good or awful. If I don't like it I just don't eat it." At lunchtime, there was a set meal with one main and a dessert available. There was no menu board in the dining room, or any menus on the tables and we did not see any information on meal choices anywhere else in the home. People were unable to tell us what they were about to be served. Meals were served on small plates and some people had difficulty keeping food on their plates when they tried to cut up their food. One person had to ask a member of staff to assist them and told us they found the small plate difficult to eat

from. We spoke with the registered manager about our concerns relating to people having a choice and the small plates. They told us, and records confirmed, that they had discussed this during a resident's meeting. However, our observations showed that this was not effective for all of the people who lived at the home. They told us that they were decorating the dining room and menu boards were not currently on display. In the interim, we saw that there was a system for people to give their menu choices which was circulated each morning.

We saw that people's individual nutritional needs were assessed and specialist advice was sought from professionals where needed, for example dietician and speech and language therapist. Staff were knowledgeable about people's specialist needs, for example, staff told us about a person who required a soft diet due to minimise their risk of choking and we saw their needs were met. We saw that staff encouraged people to eat and drink sufficient amounts and provided support when needed. A relative told us, "The staff now have to assist [Name of person] to eat at times. They always talk to them and explain what they are doing if they have to help and never rush them". We saw that people's weights were monitored and any concerns referred to the GP or dietician to ensure prompt action could be taken to maintain good health.

People were supported to maintain their day to day health needs. People and their relatives told us the registered manager and staff ensured they had access to other professionals including the GP, district nurse and chiropodist. A relative told us, "The district nurse comes in regularly and I think they liaise with them to ensure the GP is called when needed". Relatives told us the staff were proactive in getting advice when people's needs changed. One person told us, "The staff are very good. They noticed a skin breakdown quite recently. [Name of person] is in bed most of the time and needs help to move. They got the district nurse in straight away and it has been cleared up quickly. We spoke with a visiting professional who told us the staff contacted them promptly and followed their advice which ensured people's day to day health needs were met.

Staff told us and records confirmed they had received induction training when they first started working at the home. This included shadowing other staff and completing a range of training in areas that were relevant to the needs of people living in the home. We saw information was updated as needed and staff told us they had their competence checked in areas such as safe moving and handling to ensure they supported people safely. New staff had completed the Care Certificate which is a nationally recognised qualification to support staff to gain the skills and knowledge needed to work in a health and social care setting. Staff told us they received supervision and an annual appraisal which gave them an opportunity to discuss any concerns or training needs. These arrangements ensured staff were trained and supported to fulfil their role.

Good

Is the service caring?

Our findings

People liked the staff and said they looked after them well. One person said, "Staff are caring and friendly and you can have a bit of a joke and banter with them". Relatives were equally positive and felt their relations were well cared for. One said, "Staff here are caring, kind, patient and knowledgeable about [Name of person]." Another said, "You can't fault the staff here". Relatives told us the staff knew their family members well and ensured people felt at home. One said, "There is such a lovely atmosphere whenever you come. Staff are so welcoming and know all about the people in their care". We saw people were relaxed in the company of staff and we heard laughter and banter between them. A relative said, "Nobody is ever grumpy, they are always smiling. Staff showed concern for people's wellbeing and offered people reassurance and support. We saw a member of staff gently waking a person to remind them they were going to see the district nurse and observed other staff checking with people to ensure they were comfortable.

People told us they were able to make decisions about how they spent their time. One person said, "I stay in bed a lot of the time now as it pleases me to do this, but I do sit out sometimes". People's independence was promoted and staff encouraged people to do as much as possible for themselves. One person told us, "They make sure I am safe and let me do what I can for myself but they are there if I need assistance". We observed a member of staff supported people to follow the exercise programme recommended by the occupational therapist. They told us it was important to them to help people keep mobile and retain their independence.

We saw that staff treated people with respect and promoted their dignity. Staff spoke quietly with people and were discrete when asking them if they needed support with personal care. Staff ensured people maintained their appearance, for example checking people's clothes were in place after they had been supported to move. We also observed a member of staff supported a person to change their clothes after lunch when they noticed that they had spilt food on themselves.

People were encouraged to maintain their important relationships. We saw that staff welcomed visitors and offered them refreshments. Relatives told us they could visit whenever they wished and were always made welcome. One relative told us, "Staff are always welcoming and willing to help". Another said, "The staff are always very pleasant with me. In all honesty, I couldn't wish to meet a more pleasant group of staff, each and every one of them. There's a lovely atmosphere whenever you come and they ask how you are and take a genuine interest in you as a person and in your family". Relatives we spoke with told us they were kept informed about their family member's wellbeing and any issues that may have arisen. One relative told us, "They always let us know if there are any changes or issues. If it's urgent they ring or otherwise catch me when I visit".

Requires Improvement

Is the service responsive?

Our findings

We received mixed views when we asked people if they received care that was responsive to their individual needs. Some people told us they did not feel able to ask for support to get up or settle for bed when staff were having a handover meeting, during the shift changeover in the morning and at night. One person said, "I know I can't get up when they are doing the shift changeover so I wait and buzz when they have finished, even if I'm ready to get up earlier. The same at night, I may have to wait and go later than I really want to". Another said, "I know I can't get up until after handover and at night, they take me up at 6:30pm otherwise I know I will have to wait until after 9:30, which is too late". This showed us the daily routine at the home was not always flexible to ensure people received care and support in the way they wanted and at the time they wanted it.

However, some people and relatives were happy with the support they received and told us it met their individual needs. One person said, "Staff know just what I like and how I like things done and do their best to make sure it happens". People and their relatives told us about how they had been involved in decisions about their care. One person said, "The staff have always gone through the care plan with us and made sure we understood and agreed things". A relative told us, "We were fully involved in supporting [Name of person] with all aspects of the care plan, from the start, with the manager and the occupational therapist who was involved". This showed us these people were supported to receive personalised care.

People were not always offered opportunities to maintain links with the wider community to promote their wellbeing and avoid social isolation. People told us the home did not arrange for entertainers to come into the home and we saw there was no programme of events on display. A relative commented more use could be made of the garden, although as already noted in Safe, staff told us the patio doors into the garden were not used as the grounds were not secure. One person said, "I would like to be able to go out into the garden, but would need staff to go with me so I don't ask". Staff told us social events were organised, such as a visit from a small animal 'petting zoo', and a photographer who showed shots of the local community to provide opportunities for people to reminisce. However, there were no photographs that recorded these social events and no evidence to show how people were asked what activities and events they would like to take part in.

Arrangements were not always in place to ensure people were consistently supported to engage in activities. Staff told us they were supporting people with activities whilst the activities co-ordinator was on holiday. However, we saw that this was not always successful. For example, the bingo had to be abandoned because some of the balls were missing. In addition, a game of soft ball which several people joined in with was interrupted several times when the member of staff supporting people had to leave the communal lounge to support a person who was unsettled. Although another member of staff came to take over to continue the games on each occasion, it meant people's enjoyment was affected. We saw other people were supported on an individual basis. For example, a member of staff looked through a photograph album with a person and spent time discussing the pictures. One person told us they received Holy Communion on a regular basis, which showed us people were supported to follow their religious beliefs

People and their relatives told us they knew how to raise any concerns or complaints and would feel comfortable doing so. One relative told us, "Any problems and I have no qualms about going to see the manager. In my experience queries have been sorted quickly and satisfactorily". Another relative told us they were concerned about a lost item. We heard them discussing this with the registered manager who addressed their concerns promptly. We saw that any concerns or complaints were recorded and responded to in line with the provider's complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been working at the service since 2014 and had registered with us since our last inspection. However, we found that they did not always ensure they notified us of important events that occurred in the service, as required by their registration with us. As already noted in the Safe domain, they had not notified us of a safeguarding concern. In addition, the registered manager had not correctly notified us of an incident that occurred at the home which was later investigated by the coroner. This meant we did not have the information we needed to check that appropriate action had been taken in these instances.

These issues are a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The provider did not always have effective systems to ensure risks to people were effectively assessed, monitored and reviewed. As reported in Safe, we found risk assessments were not always carried out when people presented with behaviour that challenged themselves and that of others which placed people at risk of receiving inconsistent care and support. The registered manager and provider carried out checks to maintain the safety of the environment. A relative told us they had discussed their concerns about the French doors in their family member's room, "The lock can be opened by just turning a knob and I was worried as they wander all the time, looking for their partner and wanting to go home". We discussed this with the registered manager and following the inspection they provided evidence to show that measures were in place to keep the person safe whilst using the doors in their room. However, the registered manager could not show us any evidence that they had assessed the need for such measures in relation to the use of the French doors in the communal lounge. A member of staff told us the doors were locked because people would not be safe to be in the gardens independently. This showed us the provider's systems were not always effective in ensuring that any potential risks posed by the home's environment were assessed and mitigated.

The registered manager carried out checks to ensure the accuracy of people's care plans. However, these had not identified that some people's care plans did not reflect their current needs. For example, one person's mobility plan stated that they could mobilise independently using their walking frame. Records showed that the plan had been reviewed on a monthly basis and entries noted that the person's needs had changed and they required the support of one member of staff to minimise their risk of falls. However, the care plan had not been updated since March 2014 to show this. Discussions with staff demonstrated that they understood the person's needs and we saw the person being supported safely. However, failure to ensure the records were accurate and up to date placed the person at risk of unsafe care and treatment.

Since our last inspection in December 2015, we saw the registered manager had made improvements to their systems to ensure medicine stock levels were effectively recorded and monitored. However, audits of medicines had not identified the concerns we found with the recording and management of a person's anticoagulant medicine and had not ensured that staff had clear guidance on the administration of when required medicines. This meant their auditing systems were not always effective in identifying shortfalls and

making improvements where needed.

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

People and their relatives told us they were able to give their feedback on the service through resident and relative meetings. The registered manager told us and records confirmed that individual meetings were held to discuss people's concerns and improvements made wherever possible. The registered manager told us that they had recently consulted with people about the food at the home. However, people were unhappy about the lack of choice and there was no evidence to show that any changes made had been monitored to check that people were satisfied. This showed us the systems used to gather feedback and make improvements needed were not always effective.

There was a positive, inclusive atmosphere at the home. People and their relatives told us the registered manager was friendly and approachable. One person said, "The manager is always about when needed". Another said, "They often call in to see me and ask how I am and if everything is okay, which I like". We saw the registered manager was available to people and popped into people's rooms throughout the day to check how they were. We saw staff worked well together and supported each other to ensure people received good care. Staff told us they felt supported by the registered manager and provider and felt able to give their views in staff meetings. Staff were aware of the whistleblowing policy and were confident they would be supported if they had any concerns about poor practice.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. There was a copy of the provider's report available for people at the entrance where they signed in. However, this was not conspicuously displayed to ensure people were aware of the rating. We discussed this with the registered manager who immediately displayed a copy of the ratings poster on their noticeboard, which was visible to everyone. It is also a requirement that the latest CQC report is published on the provider's website, however the provider doesn't have a website, therefore this doesn't apply.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always reported significant events that occurred in the home. We had not received notifications from them for important information affecting people and the management of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. When people placed themselves and others at risk of harm, there was not a planned approach to support them or others.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always have effective systems to ensure risks to people were effectively assessed, monitored and reviewed. Care plans had not been kept up to date to reflect current information. The provider had not ensure the environment was always made safe for people.