Galleon Care Homes Limited

Highbeech Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 19, 20 and 28 April 2016.

Highbeech Care Home is situated in Bexhill on Sea and is registered to provide care and accommodation for up to 27 people living with dementia. All accommodation is offered on a single room basis. The home has a variety of communal areas for people to use. There is a passenger lift for ease of access between floors. There were nineteen people living at the home on the days of inspection.

There was no registered manager in place. The registered manager resigned in November 2015. A manager has been in post since January 2016 and we were told that she would apply to be the registered manager in the near future. 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.

Care plans did not all reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as diabetes and epilepsy did not have sufficient guidance in place for staff to deliver safe care. Not everyone had risk assessments that guided staff to promote people's comfort, nutrition, skin integrity and the prevention of pressure damage. This had resulted in potential risks to their safety and well-being. Staffing deployment and inexperienced staff had impacted on people receiving the support required to ensure their health and welfare needs were met. Accidents and incidents were not always recorded and explored fully to determine if care practices were safe and if further action should be taken to prevent further incidents. Unexplained bruising had not been followed up to determine possible cause and had not been reported to the Local Authority for investigation under safeguarding.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Where people's health needs had changed, such as not eating and drinking, care plans did not reflect the changes and therefore staff were uninformed of important changes to care delivery.
Information was not always readily available on people's life history and there was no evidence that people were involved in their care plan. The lack of meaningful activities for people, specifically those who remained on bed rest or lived with dementia, at this time impacted negatively on people's well-being.

The dining experience was not a social and enjoyable experience for people. People were not always supported to eat and drink in a dignified manner.

Quality assurance systems were in place, however there were areas that had lapsed and had not identified some of the shortfalls found at this inspection. We also found that systems were not in place to ensure that shortfalls identified through audits had been actioned by staff. For example we were told that a care plan

had been identified as not in place, and the management team had allocated it to a member of staff and assumed it had since been done. Unfortunately it had not been done.

Arrangements for the supervision and appraisal of staff were now in place. It was acknowledged there were gaps in supervision for staff due to the changeover of managers. Staff told us that meetings now took place and they felt that things would now improve.

People we spoke with were complimentary about the caring nature of some of the staff. People told us care staff were kind and compassionate. However we also saw examples where staff were not treating people with respect when delivering care. We also saw that some people were supported with little verbal interaction and some people spent time isolated in their room.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of 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 this 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?

Inadequate

Highbeech Care Home was not safe. Risk assessments were not in place for everyone and therefore placed people at risk.

People were placed at risk from equipment which was not suitable for their needs. The environment was not adequately clean and safe.

There were not always enough suitably qualified and experienced staff to meet people's needs.

Not all unexplained injuries and incidents had been reported as required to the safeguarding team.

Is the service effective?

Inadequate

Highbeech Care home was not effective.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited capacity were not always followed or reflective of individual needs.

Not all staff received on-going professional development through regular supervisions, and essential training that was specific to the needs of people had not been undertaken. Lack of end of life, management of behaviours that challenge, diabetes and dementia care guidance training was a particular concern.

Meal times were solitary and inefficient service with food being served without the support required. There was no dining experience offered. Senior staff had no oversight of what people ate and drank as not all records were accurate or completed correctly.

Is the service caring?

Inadequate

Highbeech Care Home was not consistently caring. People and visitors were not always positive about the care received. This was supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity. There was a lack of empathy displayed by staff in their interaction with people.

People who remained in their bedroom received very little attention and at times people in the communal areas were left unsupervised.

However we also saw that some staff were kind and thoughtful and when possible gave reassurance to the people they supported.

Is the service responsive?

Inadequate

Highbeech Care home was not responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

The delivery of care was not person focused and people were left for long periods of time with no interaction or mental stimulation. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

A complaints policy was in place and complaints were handled appropriately. However information received from complainants stated their complaints were not always responded with the action taken.

Is the service well-led?

Inadequate

Highbeech Care Home was not well led. People were put at risk because systems for monitoring quality were not always effective.

The home had a vision and values statement but we did not see the values acted on during the inspection.

There was a lack of leadership on the floor. Unsupported agency staff were left with people without knowledge of how to meet people's health and social needs.

People and visitors had an awareness of changes of management and felt that the new management team of the home would improve the service. The manager is in the process of submitting their application to become the registered

manager of Highbeech Care Home.

Highbeech 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.

We undertook an unannounced inspection of Highbeech Care Home on 19, 20 and 28 April 2016.

The inspection team consisted of three inspectors. During the inspection we met and spoke with 11 people who lived at the home, five relatives, six care staff members, the manager, and area manager. We also had contact with the Quality Monitoring Team of Social Services.

We looked at all areas of the building, including people's bedrooms, bathrooms, the lounge areas and the dining areas. Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the records of the home, which included, medicine records and quality assurance audits. We looked at five care plans and the risk assessments included within these, along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Highbeech. One person told us, "I know I'm safe." Another person said, "I have no complaints really but get frustrated because I feel shut in." We received some concerns about staffing numbers from visitors. One visitor told us, "I have had concerns about staffing levels at meal times and in the afternoon." Another visitor said, "I have been stuck in the building as there are key codes on doors and I have not found anybody to help me." We also found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Peoples' risk assessments were not all up to date and some had insufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. They looked at the identified risk and included a plan of action to promote safe care. However, not everyone's health, safety and wellbeing was assessed and protected. For example, three people's care plans were identified by CQC as needing immediate action to ensure their health and safety. One person had moved in from the organisation's sister home but there had been no update for four months to explain the reasons for the move, changes to the person's mobility and why they had lost weight. Another person admitted five months ago had a risk assessment that identified risk factors for skin damage. We saw following admission there had been tissue damage recorded by the district nurse with a further left leg injury being dressed in March 2016. There was no evidence within this persons care plan or risk assessment as to how the person's skin had been damaged. There were further skin injuries noted on the body map in the person's bedroom folder that were not reflected within any documentation. Staff were not able to tell us of any probable causes or of any interventions put in place to prevent further injury.

After people had moved into Highbeech Care Home people's needs were assessed and a plan of action put in place to keep them safe. We found that for one person who had been in the home for two months, this had not been undertaken. The lack of risk assessments had potentially placed this person at risk. This person had unexplained bruising, unpredictable behaviours and was not eating or drinking. Staff had not undertaken a nutritional assessment and had no baseline to monitor and mitigate risk to the person's health and well-being.

Specific health risks such as epilepsy and diabetes were not identified clearly in care plans. One person was a diabetic controlled by diet. The nutritional care plan made no reference to a need for a sugar free diet, It stated tea was preferred with two sugars. There was no information to guide staff as to how to ensure their diabetes was under control and no blood sugars taken to monitor their health. There was reference in care notes to the person being unwell recently. A random blood sugar was taken during the inspection when we suggested it might be beneficial, and was found to be 37 mmols, a normal blood sugar is between 4 and 7 mmols. It was also a concern that staff including the manager, were not aware the person was a diabetic. We saw the person being offered chocolate biscuits and sweets during our inspection by a member of agency staff. The staff member had not been told of the person nutritional needs. This placed the person at risk..

Risk associated with the use of pressure relieving equipment and the use of bedrails had not always been

assessed and used appropriately. Two pressure relieving mattresses were set on the wrong setting for individual people. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The risk of pressure mattresses being incorrect is that it could cause pressure damage. We also found bed rails that had been used with pressure relieving mattresses. The risks associated with their use had not been assessed and did not all comply with safety guidelines as the space between the mattress and the top of the bed rails were less than that recommended by The Health and Safety Executive. People were therefore potentially at risk from falling from bed. These were discussed with the senior care staff member who told us they would check them immediately.

Nutritional risk assessments were in place for most people. We saw that some people had been identified as have a swallowing problem and where necessary a referral had been made to the speech and language therapists. However we found that the guidance was not followed. For example one person who was supposed to have a semi soft diet was given a sandwich. This placed the person at risk of choking.

Accidents and incidents had not always been documented when they occurred and there was a lack of follow up or actions taken as a result of accidents and incidents. For example one person had unexplained bruising to lower back and arms which had not been reported to the Local Authority for investigation under safeguarding or investigated internally by the staff team for probable cause. Another person had a black eye which was mentioned in the daily notes but there was no incident form completed. For people whose falls had been unwitnessed by staff, there was no record of an investigation as to trends or themes and no plan in place to prevent further falls. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect people from harm. The provider could not demonstrate there had been any learning from accidents and incidents in this case.

Personal emergency evacuation plans (PEEPs) were in place. PEEPs stated the number of staff required to assist each person but there was no further information to guide staff in the safe evacuation of each person. Staffing levels decreased in the evening and night time and this was not reflected in individual PEEPs. Staffing levels especially at night would not be able to respond to the actions detailed in the evacuation plan, due to the layout of the home and only two members of staff on duty. This meant people were potentially at risk from harm from unsafe evacuation procedures. We also found that the keys to the door leading to the garden had been misplaced and this may impact on safe emergency evacuation.

The home was not consistently clean throughout and there were strong odours of urine in some rooms. We identified these to the management team. We saw some badly stained carpets in people's rooms. We were told that it had been an incontinence accident and the maintenance person was responsible for cleaning the carpets. However we were not assured that these had been identified as there was no record in the maintenance reporting book. We also saw that carpets and walls in corridors were stained and grubby, the upholstery on dining chairs and lounge chairs were stained and some sticky. The staff room/office was dirty and smelt strongly of cat food and soiled litter trays. This impacted on the homeliness and comfort of the home and was a cross infection risk to the people who lived there.

On the day of our inspection a new sensory room had been opened. Risk assessments had not been undertaken to ensure people's safety. We found some shelves had nails sticking out to hang mobiles. These were at a height that could cause skin tears and injury to people. There were also small pebbles and other objects that may be a potential choking risk to people. A beaded hanging curtain in the doorway may also prove a distraction risk to people if it caught them as they walked through. On the floor there were small artificial flower pots that were not secured, which may prove to be a tripping hazard. Other risk issues within this area were identified and discussed with the manager. In the week following the inspection, we received

concerns from a visitor that these risks had not been addressed.

The provider had not ensured that care and treatment was provided in a safe way for people and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were 19 people living in the home. We were told that the staffing levels were set at five care staff in the morning, decreasing in the afternoon to four care staff. At night there were two/three care staff. The rota showed that this was not consistent and on certain days there were four care staff in the morning instead of five. Staff and visitors told us this was not a sufficient staffing level to meet with the needs of people especially as there were people at times on the four floors of the service. One visitor told us that at times there were no staff in the communal areas and this was a concern. A staff member said, "It's difficult because a lot of staff have left and we rely on agency." During our inspection there were people who remained in bed in their bedrooms. We saw that one person on the fourth floor was only visited at coffee/tea time and meal times. This meant that the person was isolated as they were receiving end of life care and on complete bed rest. At the time of our inspection, the majority of people living in Highbeech Care Home needed support with all of their personal needs, some required two staff to assist with moving and handling.

We were told by the management team that the staffing levels were sufficient to meet peoples' needs. We saw that staff were busy throughout the day and that care was not delivered in a timely manner. Breakfast on the first day was still being served to some people at 11.00am. Personal care to assist people up for the day was still being undertaken at midday and this was not always people's individual preference. One person said, "I have had to wait for staff, I can't wash myself at the moment, it's now nearly lunch and I have only just had breakfast." One staff member said, "It's busy today and so we are struggling a bit, got some new agency carers so it's a bit difficult."

Care delivery records showed that people had not received baths or showers as their preferences stated. For some people there was a week where they had received a wash but no offer of a shower or bath. Another person had only received two washes in a week and refused personal care and not offered a wash later in the day. One staff member said, "We don't get the opportunity to offer a shower later."

Staff struggled to provide care and to supervise people in communal areas. We observed people were left for up to 35 minutes in the lounge area without supervision or interaction as staff were elsewhere assisting people and helping to transfer meals to the sister home as they were late. We also noted that people did not have access to a call bell, which isolated them further. Staff were not always able to offer assistance to meet people's individual needs.

We observed the midday and evening meal service and saw there was insufficient staff deployed to give the support people required. We saw that meals were left in front of people and some people ate very little.

Accident and incident reports recorded a number of unwitnessed falls of people in communal areas and bedrooms, this indicated that staff were not present and people were therefore not adequately supervised.

The provider had not ensured that there were sufficient, experienced and qualified staff to meet peoples' needs and were a breach of Regulation 18of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw however that medicine errors had been referred to the local authority safeguarding team and appropriate actions taken such as taking advice from the doctor. Staff described different types of abuse

and what action they would take if they suspected abuse had taken place. One staff member said "I have raised concerns before and the previous manager sent an alert to social services, I wouldn't hesitate to do it again, people need us to be alert and knowledgeable."

There were systems in place to manage medicines safely. A daily check by the senior care staff had identified serious medicine errors by an agency staff member on the day of inspection. This was immediately dealt with. Daily checks were being undertaken because of a history of poor recording, missed signatures and medicine errors by agency night care staff. Medicine administration record (MAR) charts clearly stated the medicines people had been prescribed and when they should be taken. MAR charts included people's photographs, and any allergies they had. The MAR charts we viewed were up to date and signed by staff. We observed staff when they gave out medicines. We saw medicines were given to people individually, the trolley was closed and locked each time medicines were removed, and staff signed the MAR only when people had taken the medicine. Medicines were kept in locked trolleys, which were secured in a locked room. Staff followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol. However records had not always been completed with details of why they had been given. We also noted that there was a lack of directives as to when as required medicines should be administered. For example pain charts. Some topical creams in peoples' bed rooms were out of date but still in use.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview before they started work, the provider obtained references and carried out a Disclosure & Barring Service check. Staff files had a completed application form listing their work history as well as their skills and qualifications.

Inadequate

Is the service effective?

Our findings

There were people who spoke positively about the home. Comments included, "It's an okay place to live, food and a bed," and "Nice here." However, we found Highbeech Care home did not always provide care that was effective. A visitor said, "I have had to nag staff to get them to call the doctor."

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. However we found that there were people who refused personal care regularly. One person had not received any personal care in over a month. Staff told us that it's difficult to wash people if they don't want to be.

The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. Staff were unable to tell us about how certain decisions were made such as, where people spent their time, consenting to photographs being taken or about whether people could use a call bell. One person was able to tell us clearly how they wished to be assisted with personal care but the documentation stated that that they did not have the mental capacity to make that choice. A staff member told us, "Well they can't tell us so we do what is best for them." This intervention ended with an altercation between the staff member and the person. We found that this person was consistent in talking about the incident throughout our inspection and they felt that they had not been understood. The care staff member had taken the persons towels away without asking the person if they had finished and the person thought they had been burgled. Another person was not supported to attend activities as they were identified as disruptive. This was not reflected as a decision made in respect of the mental capacity assessment. This person when we spent time with them was humorous and enjoyed interaction and had not been supported to undertake any social activity.

This told us mental capacity assessments, whilst undertaken, were not decision specific and were not recorded in line with legal requirements and were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had attended training in Deprivation of Liberty Safeguards (DoLS), which is part of the MCA framework. The purpose of DoLS is to ensure someone, in this case, living in a care home is only deprived of their liberty in a safe and appropriate way. This is only done when it is in the best interest of the person, and has been agreed by relatives, health and social care professionals and there is no other way of safely supporting them. Staff were aware that the locked front door and key pads used throughout the building, which prevented people entering and leaving the home was a form of restraint and applications had been made to the local authority under DoLS about this.

The meal service was not a shared experience or made to feel like an enjoyable event for people. It had become a task rather than something to be looked forward to. Whilst there were dining tables available, the tables were not set ready for lunch and lacked condiments and glasses. We did not observe staff ask people where they wanted to sit and eat lunch. There was no background music or attempt at conversation

between people or staff.

Ten people sat at tables. Five had been sitting there since 10:30am and their position was not changed. One person asked for another person to be taken away as they were banging on the table but this was ignored by staff.

The meal choice was not what was on the menu we were given to review. We were later told that the two cooks were working from different menus. We were not sure what menu was offered to people or how people made their choice. The choice was chicken in white wine sauce or a pasta dish. The meal was not attractively served as the portions were very large. Staff did not tell people what was on their plate they just said, "Here is your dinner" or "This is what you ordered." No one was offered a choice of drink.

We observed one person refusing their lunch, the staff member said, "I will cut it up for you." The person said, "I don't want it." The staff member repeatedly tried to get the person to eat the meal and the person kept saying "I don't want it." Eventually the staff member said, "I can get you a sandwich." The staff member didn't offer a choice of any particular type of sandwich. Sandwiches were pre-prepared and not individual to people's needs. When the staff member eventually walked away, the person ate a small amount of pasta and a small amount of the sandwich.

We noted that meals were taken away with only half eaten. Staff said that this was a regular problem. Some people had breakfast late and then lunch soon after. We were told there would be a hot option at tea time for those who did not have a dinner. Three people had sandwiches as they didn't eat any of their dinner. These three people then had sandwiches for tea as well. Food monitoring charts were only partially completed. As meal portions were not of a regular size and varied according to which cook was on duty, the recording would not be an accurate reflection of peoples' appetite. We asked staff if they told the cook or the senior of the food returned. One staff member said, "We tell them verbally but don't always write it down." This placed people at risk of not maintaining a nutritious diet. Weight records identified that there were people whose weight were unstable. We viewed the weight records for seven people and saw that four had weight loss. For example one person was gradually losing weight, 10kgs over a period of six months. No action was recorded in the care plan as to whether it had been referred to the GP and dietician or whether fortified food was being offered. One person with weight loss was on a food monitoring chart but this was not consistently completed.

Records for fluids were not all completed in full and did not assure us that people were receiving adequate fluids to maintain their health. Drinks were left with people who needed prompting or assistance and then removed still full or recorded as refused. We saw that one person on a fluid chart was receiving on average 500 mls in 24 hours. Staff when asked were not sure of whether this was sufficient to keep them well and hydrated. The fluid intake was not totalled or reflected against their urinary output. It was not apparent what the fluid chart was being used for as it was not used to inform staff if more fluids should be encouraged. This placed the person at risk from dehydration.

The provider had not ensured that people's nutritional and hydration needs were monitored and met effectively. These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Some staff told us they were behind in some areas and this was already known to the organisation. Whilst training was available it was not effective in all cases. We observed poor practice in moving and handling people, assisting people with their food managing behaviours that challenged and

in delivering person centred care. There was a lack of understanding shown by staff in supporting people who lived with dementia. This was observed by the lack of interaction when supporting them and not managing some behaviours effectively.

We looked at training records. The organisation had identified that the training needed to be improved and a training plan developed. Training records indicated that fundamental training for all staff was up to date. For example, safeguarding, health and safety. Service specific training, such as end of life care, management of behaviours that challenged, dementia, wound care, food hygiene and nutrition had not been undertaken or updated to ensure best practice was followed by all staff. The training plan told us that no staff had undertaken training in management of behaviours that challenged. We saw care delivery for people who lived with dementia was not always person focused as we saw staff make decisions for people without any involvement or discussion. People with nutritional problems were not always supported in a way that maintained their health. This impacted negatively on people's well-being.

Highbeech Care Home had a high vacancy of permanent care staff as staff had recently left the service. Agency staff were used, we were told that all agency staff undertook an induction and completed shadowing shifts before working unsupervised. However this did not happen in practice. One agency staff member was new to care and was on an induction. Whist talking to us she began breaking biscuits to help someone eat them. We asked if the person had a risk of choking? "I don't know, I don't know anything about any of them." She had received no induction to the environment or handover about the people she was supporting.

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said, "Supervision sort of stopped but we are now booked up." Staff records of supervision confirmed that staff supervision had fallen behind but was now being undertaken since the new manager had started work. Staff told us they had felt unsupported due to staff changes and lack of leadership. This was reflected in the unsafe practices we observed.

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did receive effective on-going healthcare support from external health professionals. People and visitors commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. Staff had referred people to the district nurse and speech and language therapist as required. It was however identified during our inspection that referral to external health professionals was not always done in a timely manner. For example, weight loss.

Inadequate

Is the service caring?

Our findings

We received a varied response from people and visitors about the care and support given. There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort and there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact were given very little time and attention throughout the day. Comments from visitors included, "I visit and sometimes I do not see any staff at all," and "Staff ignore people when they call out, and I worry that people might not get the care they need." We were also told that the home was not clean and some people were dressed in stained clothing.

Staff were task focused and did not always treat everyone with respect, kindness and compassion or maintain people's dignity. We undertook a SOFI which identified some staff were not interacting with people in a way that was respectful. Staff talked over people and referred to them in the third person. One member of staff said that one person, "is being difficult." This was said in front of the person involved who was visibly distressed and agitated.

People were not always treated with respect and dignity. One person told us that the water was cold when they tried to get ready and they had been washed with cold water. It was confirmed that there was no hot water that morning. We also received information that people were left exposed whilst being washed and that people did not receive oral hygiene or assistance with brushing teeth or rinsing mouths. We were able to confirm this during our inspection by observation and talking to staff. We saw there were people who looked dishevelled and some men had received an incomplete shave. Records identified that oral hygiene was not routinely offered. We found dry and unclean toothbrushes in people's rooms, which indicated they had not been used on a regular basis. One staff member said, "They don't have any teeth so we don't give them oral care." One person sat in a chair for the duration of the day in soiled and stained clothing. We observed no attempt to engage with the person as to whether they would like to move or to offer a change of clothing. Biscuits and cakes were offered with tea and coffee mid-morning and mid-afternoon. The biscuits and cakes were handed out to people without being offered a plate or napkin.

People's dignity was not always promoted in the communal lounge when they were helped to move. No attempt was made to offer privacy during the procedure and we observed one move that was a difficult and undignified manoeuvre, no verbal interaction took place and no reassurance was offered. Privacy screens were not available.

People's preferences for personal care were recorded for each person but not always followed due to rushed staff. One person said, "They snap at me sometimes if they are busy but I don't think they mean it, I missed my shower the other day, but I'm not really worried." Another person said, "I would like a bath but it's not always possible."

We observed that people's dignity was not promoted whilst receiving support for eating their meals. People were left struggling to eat without the necessary support and others were sat with their meals in front of

them for up to 20 minutes without prompting or assistance. When staff did prompt it was not done in a successful way and staff remained standing over them, which meant there was no eye contact or engagement.

Whilst staff told us people should be encouraged to make choices we didn't observe that people were offered choices. For example, meals or what they wanted to drink. A list of what people were to have for breakfast was used every morning with no choice offered. Drinks were given out from a trolley but no choice was offered. One staff said, "They always have the same." We saw one person given a plastic beaker whereas everyone else had a china cup. Staff could not tell us why this was given and presumed it was a case of being safer. This was not reflected in any risk assessment associated with the person. We also saw staff decided where people sat and when they were moved. There was no asking or involvement shown by staff towards people. One person was restless and staff followed the person, but showed no attempt to engage with the person or involve in activities. During the morning the only interaction observed was when giving people tea and coffee. There was periodic music in the background, staff did not replace the tape when it was finished and people were not offered the opportunity to watch the television or read a newspaper.

People were not always supported to be independent and make day to day decisions. We saw two separate incidents where staff removed people's cups despite the people wanting to hold on to them. There was no offer of a second drink or any thought as to leave it and return later when the person may have decided they had finished with it. One person was using the cup to gain attention but a member of staff thought it was amusing and was laughing, did not display any empathy and the person became cross. Another staff member intervened and displayed reasoning and empathy but once the cup was removed, the person was left restless. We asked staff how they supported people to make choices and remain independent and were told, "We offer resident's choices about want they want to do with their day all the time." However people were not supported to make choices about how, where and what they did on a day to day basis. We spent time observing the lifestyle within the home. People were not offered choices and people sat for long periods of time dozing in chairs or walking around the lounges and corridors.

We also saw that choice and independence were not fully reflected in people's care plans and risk assessments. There was no reflection of conversations between staff and people about what they wanted from life whilst living at Highbeech Care home, such as their social aspirations and personal relationships with friends.

The environment in Highbeech Care home which is specifically for those people who live with dementia was not dementia friendly or homely. There was limited sign posting to promote independence. For example signage for people to recognise the lounge and bathrooms. Some people's rooms did however have a name and photograph on. The lounge was separated into a sitting area and dining area and not set out to be comfortable and relaxing for people. There was no sensory equipment for people to prompt memories or encourage mental stimulation within easy reach for people. Activity accessories were kept in a cupboard and not used by staff unless prompted. We saw a skittle activity on one afternoon and that was led by a relative. There was superficial conversation at times but it did not ensure positive engagement. We were told that one of the non-participating people had severe sight and hearing difficulties, but likes animals and loud music as stimulation. However despite knowing this, the room was quiet and this person was not offered any interaction or conversation. This person remained silent and solitary during our inspection. Another person remained sitting alone at a dining table with no stimulation. The person displayed frustration caused by another person who had not understand they wanted a conversation. There was increased tension noted during our observation but no staff demonstrated an awareness of this, even when the person started clapping for attention.

A new sensory room was opened on the first day of the inspection but was not offered to people as a place to sit during the afternoon or on subsequent visits. The provider had not promoted a caring and stimulating environment for people who live with dementia. The management team were aware there was work to be undertaken and discussed their future plans for further training and workshops.

People were not consistently treated with dignity and respect and they were not encouraged to be independent or to live a life of their choice and this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. The manager told us, "There are no restrictions on visitors". A visitor said, "I visit often and the staff are always welcoming."

Inadequate

Is the service responsive?

Our findings

Whilst some people told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not responsive to people's individual needs. We were told by visitors, "A lot more could be offered, it is rather boring in here (lounge). Another visitor said, "My friend is unhappy and bored."

Communication and social well-being was an area that we identified as a concern as a large number of people were isolated either in their bedrooms or in the lounge areas with little interaction from staff. There was no rationale given by staff or any evidence this was people's choice. There were also people whose only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. Staff performed the tasks but did not use this one to one time to chat or offer reassurance. The SOFI identified that there was little empathy shown by staff to people and very little positive conversation.

We visited people in their rooms regularly throughout our inspection and saw they received little social interaction from staff apart from being given drinks and their midday meal. We observed staff waking one specific person who was on bed rest, for their midday meal. When engaged with, the person was responsive. We looked at their care plan which did not contain any information of how staff were meeting this person's social needs at this stage of their life. One staff member told us that they felt the person would benefit from an occasional trip to the communal areas if only for a short period, but had been told no by a senior member of the team as it would take staff away from other people for too long.

Care was not always personalised to the individual and did not include important changes to their health. For example, reduced mobility, falls, communication and behavioural challenges. Staff described how one person had put all their belongings on the chair ready to pack to leave. This had meant the room was not safe and the person remained unsettled and challenging to staff interventions. There was no detail in the person's care plan to offer meaningful activities as diversional management or how to manage the person's behavioural traits.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. However some people's care plans lacked details of how to manage and provide specific care for their individual needs. For example people's continence needs were not always managed effectively. Care plans stated when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking or prompting to use the bathroom throughout the day. For example, we spent time in the dining area and one person remained unmoved from 10:30 am until 16:30 pm. In that time there had been no offer of movement or visits to the bathroom.

Some peoples' specific health problems were not reflected in their care plans for example, epilepsy. One person was known to be epileptic. There was no reference to what type of epilepsy this person had or references to any known triggers.. The last seizure was recorded in January 2016. We asked a staff member what type of epilepsy the person had and this was not known. We found daily records recorded the person had been unwell for a month. This person had remained in their room for the last three days without any

regular monitoring apart from personal care and meals.

Following a fall, one person had sustained an injury that required a hospital visit and treatment. The care plan did not contain any guidance for staff to check to ensure the circulation of the limb was normal. We observed the limb was puffy and swollen and not elevated as instructed.

Care plans reflected some people's specific need for social interaction, but these were not being met. There were times when we saw that people were isolated and staff interaction was minimal due to other tasks being undertaken. The activity person was enthusiastic about their role, but told us that it was difficult to ensure everyone received an opportunity for activities as not everyone participated. We saw a knitting activity was scheduled but only two people were involved, there was no activity for others to join in with. Despite having a secure garden people were not supported to walk around or sit on the patio.

The records showed us that the activity co-ordinator spent time on one-to-ones sometimes but this was not regular. This also meant if the activity co-ordinator was visiting people in their room, the people in the communal areas were left with minimal intervention.

Activities promoted were not reflective of people's individual interests and hobbies. We were told that there were plans that involved using the sensory room and involving people in more meaningful activities. We were told one person liked to help wipe tables and tidy up but this was not pro-actively encouraged or staff led. We were told that some people visited the sister home for special events such a visiting entertainers and pet visits. However it was unclear of how often these were offered and who attended.

The evidence above demonstrates that delivery of care in Highbeech Care Home was task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw photographs that showed people enjoying visits from outside entertainers and visitors. We also saw that people's birthdays were celebrated. One person had recently celebrated their birthday and the cook had baked a cake and decorated the person's room.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format. One visitor told us, "I do complain but not sure if I'm really listened to, because I seem to always be talking to relief (agency) staff". There had been a number of complaints received in the past few months and documentation confirmed complaints were investigated and action taken. However two visitors/ told us that they had not received feedback or told of the actions taken in response to their complaint. This was an area that required improvement. We were also told by one visitor that they had gone to the office to complain and felt it was handled appropriately.

Inadequate

Is the service well-led?

Our findings

People, friends and family described the staff of the home to be usually approachable, dependant on who was on duty. People told us; "They are friendly." A relative said; "I think the new manager is making changes." A staff member commented; "The new management team are supportive, and things are getting better."

There was no registered manager in post. The registered managers' post has been vacant since January 2016. A manager had been recruited and will be submitting an application with CQC to be the registered manager of Highbeech Care Home. We confirmed with the manager that this process had started.

The provider had begun to put into place organisational audits which had identified some of the shortfalls we found but work to improve these had not progressed.

Quality assurance systems were in place, however they were not all fully completed and had not identified the shortfalls we found. We found gaps in audits from when the last manager had left and when the new manager started their role. We found that some of the identified shortfalls had not been actioned as the management team had thought they had. We found that the service had not fully established good leadership. Accident and incident reports identified that these were not recorded accurately or responded to effectively to reduce risk in the service. Repeated accidents for one person had not been pro-actively managed. Learning from these incidents had not been taken forward. For example the possible need for further training to reduce the number of injuries and implementation of strategies to respond to people when their mobility deteriorated.

The provider did not have appropriate systems in place to assess, monitor and mitigate the risks relating to people's health, safety and welfare. Areas of concern highlighted during the inspection had not been identified within any of the service's quality monitoring processes.

Leadership of the service had failed to ensure action was taken when needed. For example, risk assessments and care planning for people's specific health needs, the management had failed to ensure these were embedded as best practice in all applicable areas. Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems to identify trends and mitigate risks. Learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews.

The provider's audit systems had not identified people's risk assessments and care plans were not always accurate. A person's nutritional assessment stated they were not at nutritional risk and it also stated they were not eating poorly and did not lack appetite. This was despite the person having a very low body weight, the persons' own reports that their appetite was not good and care staff confirming that the person ate only small amounts. Additional risk factors due to the person living with a specific medical condition had not been included in their risk assessment. A different person's care plan stated they could be verbally and physically aggressive and use offensive language, specifically during personal care. The person had only had

one assisted wash in April 2016. There was no information on how the person was to be supported with personal care or how to manage their behaviours. The provider's audits had not identified the person's care plans had not set out how the person and care workers' safety was ensured when supporting the person.

The service lacked appropriate management action plans to ensure continuous improvement and development and to demonstrate learning from incidents and accidents. The quality assurance framework was ineffective because the provider failed to have effective systems and processes to ensure they were able, at all times, to meet requirements in other parts of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt their suggestions were not listened to, for example, in relation to staffing levels and deployment. The staff meeting minutes identified that staff had raised the
issue of staffing levels and staffing levels had not been increased.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and keep complete and accurate records of was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The values of the service displayed on their website and in their statement of purpose state 'Our team of highly trained, dedicated and understanding staff provides person centred care with our residents' dignity and wellbeing as their overriding concern' and 'home from home' with the highest standards of care for frail and older people suffering from dementia'. However as identified in the report the culture and values of the home were not embedded into every day care practice. The information on the website and service documentation was out of date as they refer to the previous registered manager by name. Staff were able to tell us, "I think staff changes have been needed and we are receiving support to be able to put the residents first."

Staff did not yet have an understanding of the vision of the home to provide specialist person centred dementia care and from observing staff interactions with people; it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. We saw poor practices which were undertaken by a small percentage of staff but not challenged by other staff observing. This told us that the culture of the home had still to change to ensure person centred care. Staff however spoke positively of how they all worked together as a team. They said they supported each other and helped each other when things were busy. However agency staff told us they felt 'unsupported' and 'lost' as they were not given instruction or guidance with the people in the home.

The area manager told us one of the organisational core values was to have an open and transparent service. The provider was supporting staff, visitors and the people who lived at Highbeech Care Home to share their thoughts, concerns and ideas with them in order to enhance their service. Friends and relatives meetings were planned and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, "I have been worried because there seemed to be a lot of changes, I'm not sure if the use of so many relief staff helps, but it needs to be sorted doesn't it." Another said, "We have seen changes and new staff coming in will brighten the place up."

Staff meetings had been held regularly over the past few months, and we were assured that regular meetings would be held whilst changes to the management structure continued. The manager said, "There is a lot to change, such as the culture, but I have confidence that we will get there. We know we have a long way to go but we won't give up."

We spoke with staff about how information was shared. They told us they were given handovers but felt they were not as informative as they could be but felt that the use of agency impacted on information sharing. One senior said, "As they don't know the home and residents well, they don't pick up on changes like the regular staff." They were not informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough. The management had identified this as an area that required improvement and were dealing with this through meetings with staff, investigations and supervision. We saw evidence of this during our inspection.

One staff member said that the culture in the work place was better, there were times in the past that they had felt their suggestions to improve care were not acknowledged and had felt unsupported.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision.

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 The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. The provider had not ensured the home was clean and safe for service users.

The enforcement action we took:

warning notice