Sanctuary Care Limited

Highcroft Hall Residential Care Home

Inspection report

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18 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 August and 18 September 2017 and was unannounced.

Highcroft Hall is a residential home which provides care and accommodation for a maximum 52 older people and people who lived with dementia. At the time of our inspection visit, 50 people lived at home.

At our previous inspection in August 2015, the home was rated 'Good' in all areas. During this visit we found improvements were now required in all areas and there were breaches in relation to Safe care and treatment, Good governance and Staffing.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always enough staff on duty to meet people's needs, particularly at the week-end and on the second floor of the home.

Risks associated with people's care, in particular regarding the risk of falls were not managed well. A number of people had experienced injuries as a result of falls and training provided to staff to assist people to move safely had not always resulted in safe practice.

Risks to people's well -being was not always identified and acted on. Systems and processes to monitor the quality and safety of service were ineffective in ensuring people were kept safe.

People and relatives told us staff were caring, but staff did not have time to deliver more individualised person-centred care.

There were planned activities for people, but there was not enough emphasis on activities which reflected the hobbies and interests of individual people. The activity worker and care staff did not have enough time available to fully meet people's social and emotional needs.

Staff understood how to safeguard people from harm, and the provider's recruitment process reduced the risks of employing staff unsuitable to work in the home.

People had a choice of meals and mostly enjoyed the food provided.

Medicines were managed safely, and people received healthcare which met their needs.

Staff understood the principles of the Mental Capacity Act, supported people to make informed choices, and where necessary acted in people's best interest.

People and relatives mostly felt their concerns or complaints were listened to and addressed. Complaints were managed in accordance with the provider's complaints policy and procedures.

The provider had systems in place to identify and act on poor practice; however, not all of what we saw during our inspection visit had been identified by the registered manager or provider.

You can see what action we told the provider to take at the back of the full version of the report

The overall rating for this service is 'Inadequate' and the service is therefore in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspection again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

There was not always enough staff on duty to meet people's needs in a timely way. Individual risks to people's health and well-being were not always managed well, in particular in relation to the risk of falls. Staff knew how to safeguard people from abuse, and recruitment procedures reduced the risks of the home employing unsuitable staff. Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Training to support staff move people safely was not effective as we saw unsafe 'moving people' practice. Other training supported staff to meet people's needs well. The provider complied with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. There were mixed views about the quality of food provided. People were supported to maintain good levels of hydration. Healthcare professionals attended people when required or requested.

Is the service caring?

Requires Improvement

The service was mostly caring.

Staff were kind to people but did not have time to provide 'person-centred' care, and sometimes were too busy to see or respond to people's care and support needs.
People felt staff treated them with dignity and respected them as individuals. Staff knew people well. Visitors were welcome in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a planned programme of activities, but there was a lack of activity planning and time for developing individualised activities which reflected people's interests and hobbies. The

service involved people and relatives in discussing fundraising and in activity planning but there was scope for further regular engagement with people to seek their views about their life in the home. Most people and relatives felt complaints or concerns were managed well.

Is the service well-led?

Inadequate

This service was not always well-led.

Systems and processes to monitor the quality and safety of service were ineffective in ensuring people were kept safe. The provider and management team had not identified the issues with their staff's 'moving people' practice, or the concerns relating to staff numbers and staff deployment. They had identified other areas of concern and were working with the registered manager to improve on these. Most people, relatives and staff felt the manager was approachable and responsive to any concerns raised.

Highcroft Hall Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 August 2017 and 18 September 2017 and was unannounced. The inspection team consisted of three inspectors, a specialist advisor and an expert by experience. The specialist advisor was an Occupational Therapist (OT). They supported us with this inspection because we had received concerns that people who needed assistance with their mobility were not being supported safely. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we looked at the information received from our 'Share Your Experience' web forms (these are forms provided on our website which people can complete to share their experiences of care); and notifications received from the provider (these are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare). We also contacted the local authority commissioners to find out their views of the service provided.

During our inspection visit we spoke with five people who lived at the home and six relatives. We also spoke with six staff (including care, kitchen and activity staff), the registered manager, deputy manager, the regional manager and the client development manager. We also spoke to a visiting continence nurse and visiting advance nurse practitioner.

For a large part of our visit we engaged with people and staff in communal areas of the home and also undertook a 30 minute SOFI (Short Observational Framework Inspection). We used the SOFI to help us assess whether people's needs were appropriately met and to identify if people experienced good standards

of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We checked the administration of medicines, looked at two recruitment records, eleven care files, and care plans of people who required support with moving. We also looked at activity records, the complaint record and records' the management team maintained to ensure the smooth running of the home and the health and safety of people who lived at Highcroft Hall.

Inadequate

Is the service safe?

Our findings

At our last inspection in August 2015, 'Safe' was rated 'good'. At this inspection visit we found concerns relating to people's safety that had not been acted upon. This had resulted in people experiencing harm.

Prior to our inspection visit we had received concerns that people who lived at Highcroft Hall and who needed assistance to move around the home or from one position to another were not receiving this assistance safely. We then received further information during the inspection that a high number of people had suffered injuries as a result of falls. Our specialist advisor looked at the care records of people who required assistance with moving and during our visit checked how staff supported people with their mobility to reduce risk of falls or injury.

We found people were not always supported to move safely. For example, on one occasion a person was sat on a sofa in a slouched position and was sliding off the sofa. Two care workers attempted to help the person stand. They did not explain what they were about to do and tried to pull the person up with their hands/arms under the person's armpits, pulling on both the person's hands. This had the potential to cause injury, damage the person's skin and risk unintentional bruising. Fortunately, the person stated, "Tell me what you are doing first and I can help." At this point the care worker then spoke about what they were doing and the person was able to assist with a safer move.

On another occasion we saw two care workers assist a person to stand from a seated position. The care workers spoke to the person but the person declined to help them. This resulted in staff holding the person up under their arm pits in an attempt to move them. The person began to lean back heavily. A member of staff then held on to the person's hands pulling them to walk. The staff member walked backwards holding both the person's hands. This again increased the risk of injury unintentional bruising and increased the risk of the person falling on the floor. We looked at this person's care plan . It confirmed that when the person struggled to stand, staff should use a stand aid and sling (equipment used to help move people safely) to help them. Staff were not working in line with the care plan.

We looked at the equipment used to support people with limited mobility. We found people did not have their own individual slings (for use with a hoist), or slide sheets (used to help people be repositioned in bed). We were concerned this presented an infection risk as people had to share the equipment; and also meant more time was taken by staff trying to find the equipment when it needed to be used. After our inspection visit we spoke with the registered manager. They confirmed to us the provider was purchasing new slide sheets and slings to make sure each person had their own. We also found one person being supported to move with an access/toileting sling and not the full body sling recorded in their care plan. The toileting sling had less support and was not suitable for all people. A formal assessment was required before people could use this and no formal assessment had been carried out.

We were also concerned that where people required personal care in bed (such as a bed bath), the person's bed was not height adjustable, not on a wheeled base and positioned against a wall. This meant staff had to bend down low and remain on the same side of the bed to support the person. This was a high risk to staff in

relation to potential injury, and increased the risk of injury to the person as staff were not in optimal positions to support people safely.

Systems which supported staff to ensure people' risks were reduced, were not always being used. For example, we identified from records that one person had been assessed as needing the support of a hoist to transfer safely. On the second day of inspection, we saw this person being supported by staff to walk with a frame. We raised this with the deputy manager who informed us that this person had requested that a hoist was no longer used as they wished to walk. Staff had then commenced supporting the person to walk, even though this had not been assessed as being safe for the person to do.

We found a number of falls had been recorded. We saw that people's risks of falls had been assessed but action plans had not been completed for those considered at higher risk; and we found one person who had fallen twice within a one week period had no further action taken to help prevent this happening in the future. Another person had been identified as not sitting in a safe position when seated in their chair and records we looked at showed this person had experienced a number of falls from the seat. We saw that staff were aware that this person was sitting in a way that could increase the risk of falls but failed to take action to keep the person safe when they had seen the person sat in an unsafe way.

We found some people's risks of falls were increased because they were either not wearing footwear, or not wearing footwear which was safe. For example, one person was not wearing shoes or slippers and used a walking frame. This increased their risk of injury. Another had 'slip on' slippers. This increased the risk of falls because the person's toes would 'claw' to keep the slippers on which could affect their balance and increase their risk of falling. Another person had slippers which were too large for them and when walking with a frame, we saw their slippers were falling off.

As well as some people wearing inappropriate footwear, we found one person whose frame should, according to their care plan, be near them at all times. We saw twice during our inspection they were without their frame near them. On one occasion it was found in another person's room.

We spoke with the registered manager about the concerns identified around people's falls risks and found that they were aware of the people we identified being at risk, or having had fallen previously but had not taken action to ensure the risks were reduced in future. This meant that people were at risk of further injury or harm as action had not been taken where risks were identified.
We also found people identified as being at risk of skin damage from putting too much pressure on their skin by sitting or lying in one position for too long; should be repositioned to reduce the risk of pressure sores developing. Each time a person is repositioned the provider expected a record was kept of the time the repositioning took place and how the person was repositioned. We found not all people who required two to three hourly repositioning, had a repositioning record in place. This meant we could not be certain the person was repositioned according to their care plan. Where a record was in place, recordings were not always consistent with the care plan.

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

Staffing levels did not always meet the needs of people who lived in the home. We were told by the registered manager and staff, the provider's policy was that nine staff on duty was the minimum staffing level for a home the size of Highcroft Hall. At the time of our visit the provider was working to their minimum staffing level. This meant there were two care workers and one senior care worker who supported people on

each of the three floors from 8am to 8pm; and five care staff covering all three floors after 8pm.

The deputy manager and registered manager told us they felt staffing levels were safe because they, and the activity worker could be called on during the day to provide additional support if necessary. However, the managers and activity worker did not work at the week-ends, in the evening or at night.

Twenty people were supported on the second floor, many of whom required additional assistance with personal care, support with eating, and support with moving. People and relatives we spoke with were concerned that people's care needs had increased and staffing levels had not changed to reflect these. For example, one person said, "It's gone down-hill since it opened. They're getting a lot of dementia people – it changes the atmosphere, especially at night. They walk about, shout and come into my room." Staff told us when people required assistance with moving only one member of staff was then available to support everyone else on that floor, and if that member of staff was then asked to assist another person with their care there was no member of staff available to check people were safe.

Staff told us they found it very busy on the second floor. One told us mornings were a particularly challenging time for staff. They said people wanted to get up at the same time, and there were not enough staff to help people use the toilet and help with personal care. They went on to tell us, "Sometimes people have to wait 20-30 minutes, it is not fair on them having to wait. We can't get to people on time and accidents happen."

During our visit, at a busy time of the day (lunchtime) we saw a person wanted to move out of their wheelchair to sit on a dining room chair. The person repeatedly told staff they wanted to move, but staff could not respond to the person's request because another member of staff was required to support the move and none were available. After 20 minutes, the person had still not been supported to move. A person who required assistance with moving told us, "They're so busy here. There's only so many here and they have got to look after a lot of us. I have to be lifted by the machine. They keep saying 'I won't be a minute', I know they're busy but they could do with more hands."

People and relatives generally felt that staff were 'stretched'. One said, "I think there's just about enough staff but staffing levels have gone down a bit." A relative told us, "They're [staff] always running around but I think the staffing is rubbish. Having said that, I've never worried for [person] – they're kind."

The registered manager acknowledged that since our last inspection visit, people's care needs had increased but staffing levels had stayed the same.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014, Staffing.

Staff understood their responsibilities to safeguard people from harm. We asked staff what they would do if they saw either, another member of staff shouting at a person, or, moving a person unsafely and not as agreed in the person's care plan. All staff told us they would firstly make sure the person was safe and supported and would then report what they saw to their manager for them to take further action.

The provider's recruitment procedures helped protect people from harm and minimised the risks of employing unsuitable staff at the home. This was because reference checks and disclosure and barring service (DBS) checks were carried out prior to the person starting work. The DBS provides information about a person's criminal record. Staff confirmed to us they were not able to start work until their references had been returned and checked by the provider.

The home was well maintained and records demonstrated there were regular checks for fire safety, gas and electric safety, water safety and to make sure the equipment used was safe. Evacuation procedures were displayed throughout the building and people had individual evacuation plans to help fire and rescue services evacuate the premises if the need ever arose.

Medicines were managed safely. One person told us, "They're very careful with the medications and what time they give them.' And another said, "I'm diabetic. I do get my insulin at more or less the same time each day. I have to eat something at the same time. It's well managed though, thank goodness." We saw senior staff administer medicines to people. They took their time and made sure people had taken the medicines given to them.

We checked the medicine administration records of five people and found these accurately reflected the medicines they had been given, and the stock of medicine available for them to take. Records for stronger medicines which required tighter controls and recording were also accurate and completed in line with best practice guidance. We saw all medicines had been stored in line with manufacturer's guidance

Care plans for medicines given 'as required' were also in place for each person. These described how people, who could not verbally communicate, might indicate their need for medicines, for example, through expressions of pain. Two care plans for medicines given for constipation on an 'as required' basis were not quite so detailed, and this meant staff might not know when to support a person with this medication.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in August 2015, 'Effective' was rated 'good'. At this inspection visit we found improvements were required.

We found that for some people, the need for additional health care support had not been identified and acted upon in a timely way. We saw that one person had been seen by a GP and it had been recommended that a dietician was contacted to support the person's nutritional needs. However a month later, this referral had still not been completed and the registered manager had failed to follow this up to ensure that the person's needs had been met. We saw that other people had care needs that could have benefited from physiotherapy or occupational therapy input but the need for this support had not been identified or acted upon by the registered manager. We spoke to the registered manager about our concerns who informed us at the end of our visit that they had acted upon our feedback and made referrals as needed.

People we spoke with told us they had access to health care when needed. One person told us, "The optician and the dentist come here and the Doctors come every Tuesday and Friday. They take you to your room with a senior member of staff and talk to you there." A relative said "[Person] has access to all the health professionals she needs. The chiropodist is coming in this week." During our visit we spoke with the advance nurse practitioner (a nurse who has authority to prescribe) and an incontinence nurse. The advance nurse practitioner told us they visited the home on average twice a week. They told us care staff were knowledgeable about people's needs and staff knew when was the right time to contact them to get their support. The continence nurse also told us staff were helpful and made appropriate referrals to them.

Staff had received training the provider considered mandatory to support people's health, safety and well-being. This included training to assist people to move safely, and the mental capacity act. During our visit we found staff mostly provided effective support to people. However the training they had undertaken in assisting people to move, had not adequately equipped them to do this safely and effectively. For example, one person moved with the aid of a walking frame. When they wanted to get up from their seat, they were advised to hold on to, and pull up on the frame. Similarly, when they went to sit back down again, they were advised to hold the frame and lower to sit down. This was unsafe.

Staff had also received training to care for people who lived with dementia. A relative told us their relation lived with dementia and could behave in a way which was challenging to others. They told us staff knew how to support the person when they became "angry". Another relative told us staff had worked with them in using techniques which could calm the person.

Staff told us they received regular individual supervision meetings, and felt supported by the senior care workers and management team. Staff new to care undertook the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. Staff confirmed when they first started work at Highcroft Hall they were given induction training and time to work with and get to know people's needs before they were counted into the staff rota numbers.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw one member of staff restrict a person's movement within the home. The person wanted to get from one place to another and the staff member told them they could not do this without giving a reason; the same staff member also told another person that they 'had to go and sit at the table for tea' when the person had previously told them they did not want to. This meant the member of staff was not working to the principles of the Mental Capacity Act. This member of staff did not normally work at the home. They had been brought to the home from another of the provider's homes to support the inspection. We saw all other staff supported people with their wishes and checked they consented to any actions the member of care staff was proposing.

We found where people were assessed as not having capacity to consent to their care and treatment, DoLS applications had been submitted to the local authority who were the supervisory body responsible for authorising applications. Whilst care records clearly showed where people did not have capacity to consent to being at Highcroft Hall, they less clearly showed the capacity people had for making day to day decisions and choices. Staff however, had a good knowledge of people's capacity to make these choices.

People were supported to eat and drink and to maintain a balanced diet. However there were mixed opinions about the quality of the meals provided. We were told that sometimes the meals were well presented and thoroughly enjoyed by people, and other times they were not cooked as well. For example, one person said, "When the main chef is on, it's very good but when anyone else is on, it's not so good. There's plenty of food and there's always an alternative." Another person told us, "I don't enjoy the food. It seems sloppy to me. I don't say anything. I don't want to cause any trouble; I'm not that kind of person."

However, relatives we spoke with were more complimentary. They told us, 'The food is good here and they get plenty of drinks.' And, 'The food looks decent. She has a big breakfast and a mid-morning snack. Come lunchtime, she's not hungry but she gets snacks when she's hungry. I'm not worried about it." After our visit the registered manager confirmed they were going to provide additional support to kitchen staff who supported the main chef.

During the day we saw people were encouraged to drink both hot and cold drinks. The kitchenette within each communal lounge area meant staff could respond quickly to the requests of people who were using the communal area.

We found where people had specific nutritional requirements such as a pureed diet, or diabetic diet, these were provided for. People were provided with support to eat their meals at their own pace.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in August 2015, 'Caring' was rated 'good'. At this inspection visit we found improvements were required.

People told us staff were caring. One person said staff, "Don't get cross or nasty with you. They're lovely. Some of them can't do enough for you." Another told us they had a sensitive physical condition and felt staff were "very kind" and their responses to their condition never left them feeling embarrassed.

During our visit we spent a lot of time in communal areas and saw how staff engaged with people who lived in the home. We found staff were caring and kind when providing people with assistance, and had a good rapport with people. For example, when a person was being hoisted, they jokingly shouted out 'haberdashery', and this prompted a conversation between them and the person about a well-known local shop.

On another occasion, we saw a person coming back from the hairdressers and staff remarked on how lovely they looked after having their hair done.

However, the engagement we saw with the staff who regularly worked at the home was when they supported a person with a task. For example, in the morning of our inspection visit we saw staff being kind and helpful but always 'on the go' undertaking different tasks. In the afternoon we saw staff sit and chat with people. We noted there were more staff available than identified on the staffing rota. The provider told us they had brought in additional staff from a different home to support the inspection (they said in-case staff were helping inspectors with the inspection visit) and this meant there were more staff than usual. We saw people enjoy the attention that the additional staff afforded them.

With the provider's minimum care staffing level at the home, people and staff told us staff usually did not have time to sit and talk to them for any meaningful length of time and any discussions were when care was being provided (task focused). One relative said, "I haven't seen staff sitting and chatting with people." They went on to say their relation could forget to go to the toilet, and they did not think staff prompted them to do so. This meant the person could experience incontinence.

On the second floor, during lunchtime we saw a person who showed signs of anxiety and being in pain. Staff did not notice this because they were busy undertaking other tasks. One of the CQC inspectors had to alert staff to this.

People and relatives felt staff supported their privacy and dignity. One person told us, "They always knock before they come in and it's up to you to choose your own things [clothes]." A relative told us, "They've [staff] just asked us to leave the room while they make her comfortable. They do talk to her."

We saw people's privacy was promoted through shutting bedroom doors when personal care was provided. People had the choice of staying in their own bedrooms or using the communal areas of the home. We saw

that the quiet lounges at the end of each floor were seldom used. We spoke with a relative in one of the quiet lounges. They told us they had never been in the lounge and did not know it existed. With only three staff on each floor, staff were based in the main communal lounge/dining room of each floor.

Staff knew the people they supported. They told us they understood people's needs through reading their care plans and through staff 'handover' meetings at the beginning of their shift. This was where they 'handed over' information about people's changing needs since the shift were last on duty.
Relatives told us they were involved in planning the care for their relation. Whilst the registered manager told us senior staff involved people in their care planning, the people we spoke with could not remember being involved.

People looked well supported in maintaining their personal appearance. We asked whether people had a choice of male or female care workers to support them with personal care. Nobody we spoke with had specifically requested either a male or female care worker, but felt if they had asked for a male or female care worker the service would support them with this request. Some of the ladies we spoke with told us they had male care workers support them but told us they were 'fine' with this. One person told us, "I think they'd try if I said I didn't want male carers but the ones we've got are very good."

Relatives and friends of people who lived at the home were welcomed to visit at any time of the day or evening. One relative told us, "Family can come whenever. There's no restriction on that at all." Relatives also told us they were involved in fundraising events to support the home.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in August 2015, 'Responsive' was rated 'good'. At this inspection visit we found improvements were required.

We looked at social activities provided by the home. On the day of our visit we saw people thoroughly enjoying an exercise activity undertaken by an external organisation. We saw people engaged well with the exercise instructor and had fun. This person came to the home once a fortnight. We also saw planned activities such as a canal trip, and pet therapy.

We found that whilst organised activities were enjoyed by people, activities which supported people's individual interests and preferences on a daily basis were limited. The activity worker supported activities from 9.30am to 3.30pm Monday to Friday. They felt this gave them sufficient time to meet people's social needs and interests. They said when they were not on duty they provided staff with ideas about activities the care staff could provide to people.

At the time of our visit there were 50 people who lived at the home. The activity worker had six hours a day to meet people's social needs. There were not enough staff on duty to provide care other than task led care, and the number of staff available to do this was reduced at the week-end as there was no management cover.

A relative told us," They could do with more activities but I don't think they have much time." A person told us, "[Staff member] is the Activities Co-ordinator ... She gets plenty of ideas about things to do but doesn't get round to many of them. I get bored easily I do. Always have." When we looked at records the activity worker kept on the individual activities undertaken with each person they did not give us any real insight into what had been achieved. We did not think there were sufficient individualised activities for each person.

We looked at how the service promoted equality and diversity. At the time of our visit not everyone at the home was white British. All people were identified as heterosexual. The regional manager told us they were responsive to all people who came to the home, and would support their individual cultural, religious, gender and sexuality needs.

We saw how people's religious needs were supported. We were informed by a relative that a priest came to the home for communion every Thursday and there was a service once a month. A person told us, 'On Thursday, the priest comes in to bring me Communion. She comes to me in my room so it happens privately.' Another person told us, "I'm a Ukrainian Catholic. My family come and take me to church and then we all come back here. It's very important for me to be able to go. I love church. It's where you know where you start and where you finish."

We asked the regional manager how they supported people from the LGBT community (Lesbian, gay, bisexual and transgender). They said they had different groups within the organisation to support staff from the LGBT community and so knew the provider was positive about supporting people from the community.

They acknowledged their website and information about the service did not reflect their inclusivity. They said they would discuss this with the provider and staff to look at ways older people in same sex relationships would know they would be welcomed into the home.

People were assessed prior to moving into Highcroft Hall to make sure the home could meet their needs. However one person was assessed as being suitable for the home; and the home had not been able to meet their needs safely. The regional manager told us the service had learned from this, and had made sure there was management oversight of everyone's assessment before a place was offered.

We looked at people's care plans to see if they reflected how people would like to receive their care and support. These provided enough information to support staff in knowing people's needs but were not written from the perspective of the person. For example, one person's dementia meant they often walked around at night time. Their care plan stated if staff 'tried to sit' [the person] down they would become 'aggressive'. There was no analysis from the person's perspective about why they might become aggressive if staff were attempting to get them to do something they did not want to do.

We also found written in the person's behaviour and communication plan that they 'can be quite stroppy'. This was demeaning to the person, and did not seek to answer the question as to why their behaviours might change. The registered manager informed us that care plans had been identified by the provider as requiring further work and they were in the process of improving these.

We looked at how the provider managed complaints. On the whole we had positive comments about how complaints were managed. People told us, "I'd go to [the managers] if I was concerned; they're all approachable." And 'We've raised a few minor concerns over the years. For example, we mentioned that we didn't feel [Person] was getting enough drinks but have always been satisfied with the response." However, during our visit, the relatives of one person told us they were not satisfied with the way a recent complaint had been managed. We asked the regional manager to address these concerns directly.

The provider sought the views of people who used lived at the home via an annual 'resident satisfaction survey'. The last survey had been conducted in 2016. This told us that 98% of people were satisfied with the service, and 100% were happy overall. We discussed whether the format for the survey might be useful in looking at how individual people felt about the care provided as part of the 'resident of the day' initiative. This initiative meant that once a month, staff spoke with the person or their relative to get to know people in more depth, to find out what their likes and dislikes were, as well as updating any care or support requirements.

The home had relatives and residents meetings. These were mostly focused on fundraising for the home and arranging trips and activities. They did not appear to be a forum where other feedback about people's life at Highcroft Hall could be given (for example, about the food or laundry).This was discussed with the registered manager who said they would consider widening the scope of the meetings.

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2015, 'Well-led' was rated 'good'. At this inspection visit we found significant shortfalls in systems to monitor the quality and safety of care provided to people who lived at the home.

During the inspection we received information that people had experienced a high number of falls which had resulted in injuries. We looked at the records of accidents and incidents held in the home and found this to be the case.

We spoke with the registered manager about how they and the provider ensured they reviewed and learned from accidents and incidents to reduce the risk of reoccurrence. The registered manager told us that they completed a monthly accidents analysis to monitor whether there were trends or themes in the accidents reported. However, when we looked at records, we saw that the analysis of accidents had not been completed consistently, and for some months had not been completed at all. We found that for some people living at the home, there were patterns emerging with regards to their falls; for example, one person had fallen from bed on three occasions and another had two falls from a chair. However, as an analysis had not been completed, these patterns had not been identified and so no action had been taken. This meant that they had failed to adequately monitor the number of falls and review accidents that had occurred to ensure risks to people could be reduced in the future.

Other audits completed by the registered manager had not been effective in identifying the issues we found at this inspection. For example, we asked the registered manager whether the care plan audits included checks of daily charts such as repositioning charts as we had found these were not always completed. We were told that they had not been and it had not been identified by the registered manager that daily records were not being completed accurately. They told us that since our inspection visit they were making sure on a daily basis that the charts were fully completed.

The care plan audits had also been ineffective in identifying where action was needed but had not yet been taken. For example, we saw that some people had been losing weight. This had been recorded in people's care plans but had not been identified or acted upon as part of the audits completed. Where action had been taken for people identified as experiencing weight loss, it was not always recorded within the care records.

We looked at records held on falls and the documents available for staff to use. We found that although assessments had been carried out with regards to people's falls risks, these assessments were not always clear and did not explain in detail how people should be supported to reduce the risk of falls. For example, records we saw were not personalised and did not always contain information important to the person's risk of falls; such as previous falls, health conditions or medication that may increase risks. After the inspection visit, we were informed by the registered manager that the assessments in place for falls risks would be reviewed and updated to ensure they clearly detailed risks to people

Despite a number of issues around moving and handling practice, the provider and registered manager had

not identified any concerns in the way staff supported people to move. They informed us after the inspection visit that all staff were having refresher training to ensure they knew how to move people safely.

The provider and registered manager had failed to recognise that the dependency levels of the people living at the home had impacted on the number of staff available for people. It was acknowledged by the registered manager that people's dependency levels had increased but no action had been taken to review whether the increase in need could be managed within the current staffing levels or whether additional staff were required. This had resulted in insufficient staffing levels and people experiencing extended waits for support. This had not been identified as an area of concern. Following the inspection visit, the regional manager informed us that people's care needs would be reassessed in order for a staffing review to take place.

Staff told us they found the manager approachable but a couple of staff felt that whilst they could go to management with problems, these were not always responded to in a timely way. One member of staff told us they had raised concerns about one person's falls risks previously but it had not been acted upon. The staff member said, "It falls on deaf ears." The registered manager told us they were not aware that some staff had concerns about the levels of staffing at the home. Since our inspection visit they had discussed the issues with staff and were looking at how staff concerns could be addressed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014, Good Governance.

The registered manager was supported by a deputy manager and three senior care workers. People and relatives we spoke with generally held the manager in high regard and thought they were open to listening to their views or concerns. One person said, "Overall, I've been happy. [Registered manager] will help in any way he can. He's very approachable."

The Provider Information Return (PIR) told us the registered manager had an 'open door policy' which helped people and staff 'feel at ease' to bring concerns to them. They told us concerns raised were documented and feedback was given to staff to 'ensure they are aware of how all concerns are dealt with in a timely manner.'

We looked at checks carried out by the provider and registered manager. We were informed the provider had a quality assurance team. They visited the home in December 2016 to undertake an internal quality assurance inspection. The provider used the same rating system as the CQC. The home was rated by the provider as 'inadequate'.

Since then, the provider and registered manager told us they had worked hard to improve their internal rating and at the last visit the quality assurance team rated them as 'requires improvement'. The main issues identified were poor care planning and that staff had not undertaken the training required of them by the provider. To help give existing staff time to improve the care plans and undertake training, additional staff provided support for a period of six months until June 2017. The registered manager told us they hoped their next internal inspection would show a rating of 'good' as they were confident of the improvements made.

Staff were supported in their work through individual meetings (supervision) and through regular team meetings. We saw that concerns raised by families had been discussed at these meetings, and issues relating to quality of care were addressed.

The regional manager carried out monthly checks of the service, and any improvements identified were added to a 'Service Improvement Plan' (SIP), which the registered manager worked to, to make sure improvements were made. The SIP was linked to CQC regulations. This was to show whether the home was compliant with the regulations, and if not, which standards required addressing.

The PIR gave us a lot of information about what the service was doing well, but did not reflect on some of the challenges it had faced and how the provider's systems had identified where improvements were required.

The registered manager understood their legal responsibilities to notify us of incidents which affected the health and well-being of people who lived at the home. The provider also had a legal duty to publicise their inspection rating both in a visible area within the home, and on the provider's website. We found the provider had carried out these legal duties.

Following our inspection visits we shared with the provider and registered manager our concerns about the quality and safety of service provided at Highcroft Hall. They sent us an action plan outlining how they would address the issues raised. They agreed to not admit any further people to the home until improvements had been made.

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 12 HSCA RA Regulations 2014 Safe care and treatment Staff did always not have the skills to move people safely. Risks to people were not always identified and acted on. Equipment provided for moving people was not sufficient or appropriate to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had not identified and acted upon risks to keep people safe. Audits were not effective in identifying where action was needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels did not meet the changing needs and circumstances of people who lived at the home.