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Glenarie Manor

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 was an unannounced inspection carried out on 19, 20 and and 21 September 2016. Glenarie Manor is a nursing home which supports people living with complex mental health needs. The home can accommodate up to 26 people. At the time of our visit, 24 people lived at the home.

The home is a large, victorian house situated in Sefton Park. Local shops and public transport are within walking distance. Accommodation consists of 26 single bedrooms. On the ground floor, there is a communal dining room for people to use and on the first floor there is TV room and games room.

At the time of our inspection. There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run'.

We asked the provider about the lack of a registered manager. They told us that there was currently an acting manager in post. The acting manager had previously been employed at the home as the deputy manager. The provider told us the acting manager had not yet applied to become the registered manager. This meant that the acting manager had not been verified by The Care Quality Commission (CQC) as a 'fit' person. The provider and the acting manager were requested to ensure an application to become the registered manager was submitted without further delay.

During our visit, we found that the provider did not have a clear understanding of people's needs or the care they required yet they were heavily involved in the day to day management and delivery of the service. It was clear from what we saw and from our discussions with the provider that the provider controlled the management of the service. When we spoke with the provider during the visit, they told us that they did not own the home. They told us the home was owned by another person. This was not known to The Commission prior to our visit and had not been previously declared. We had concerns that the owner of the home was not registered with The Commission as a 'registered person'. We spoke to the provider about this. The owner was intermittently available in the home throughout our visit.

During our visit, we identified serious concerns with the health, welfare and safety of people who lived at the home. We found multiple breaches of the Health and Social Care Act regulations that placed people at serious risk of harm. We found breaches in relation to Regulations 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 and 19 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

We spoke briefly to three people who lived at the home. Of the three people we spoke with, two were happy with their care, one was unhappy with the way they were cared for.

We found that a number of safeguarding incidents had not been documented or appropriately reported.

This meant that there was no evidence these incidents were properly investigated and responded to by the provider. There was no evidence that staff members including the provider and acting manager had received regular safeguarding training. This meant there was risk staff would not know what to do in the event of an allegation of abuse being made. During our visit we had serious safeguarding concerns about the way in which care was delivered and the way in which people were treated. After our visit we made safeguarding referrals for each person who lived at the home. These safeguarding concerns are currently under investigation by the Local Authority and the Police.

We found that staffing levels and the deployment of staff during the day was poor. Staff did not engage with people in any meaningful way and there were no planned social activities to promote people's mental well-being. This increased the risk of people becoming socially isolated.

Staff were not recruited safely. Some staff were recruited without appropriate references or criminal convictions checks being undertaken. Care staff received poor supervision and nursing staff received little clinical supervision in their job role. This meant the provider could not be sure staff employed were suitable to work with vulnerable people. The skills and abilities of the staff team had also not been appropriately assessed to ensure they had the skills to work with vulnerable people.

Staff records showed that staff had not received suitable training to do their job role effectively Care staff had received no formal training in mental health or any other health and social care topics on a regular basis. The provider acknowledged this. This meant the provider could not be sure that staff knew how to provide safe and appropriate care to people with complex needs. This placed people at risk of harm.

The management of people's medication was unsafe. They did not demonstrate that people always received the medicines they needed. Medication administration records were poorly completed which made it difficult for medications to be accounted for. Some of the medication in the home was out of date and unfit for use. Other prescribed medicines had had the dispensing labels removed, but had been kept for general use within the home. This is illegal. Medicines prescribed for one person must never be used for someone else.

We reviewed five people's care records. Care plans were brief, did not accurately reflect people's needs and wishes and were not person centred. People risk assessments failed to provide staff with any guidance on how to manage people's risk sand care for them safely. This placed people at risk of harm.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not been adhered to. People's capacity to make their own specific decisions had not been assessed and there was no evidence that any best interest meetings had taken place or least restrictive options explored when restrictions on people's liberty were implemented.

People's mealtimes and access to food and drink was restricted to certain times and people were unable to have anything to eat or drink outside of the dining area. Mealtime menus were displayed in the dining area but on the day we visited people's lunch did not match what was advertised. One of the people we spoke with said they did not think they could ask for an alternative meal if they did not like what was on the menu.

We spoke to the cook on duty and found that they had a limited knowledge of people's dietary requirements. When asked, they were unsure who was on a diabetic diet. This meant there was a risk people who lived with diabetes would not receive a diet suitable to their needs. The cook also had no clear understanding of the cultural diet one person required or the foods that were acceptable to them.

People's independence was not promoted. A structured rehabilitation programme was promoted by the provider but we found no evidence that this programme was in place. People were restricted in how they lived their lives due to daily regimes imposed by the provider and we saw limited evidence that people were treated with compassion or that the provider cared about people's welfare. People were sometimes subject to disciplinary action if they failed to follow house rules.

The premises was well maintained. There were safety certificates in place for the home's passenger lift, electrical installation and moving and handling equipment. We found however that the provider's gas safety certificate was out of date and improvements required by Merseyside Fire Authority in relation to the home's fire safety provision had not been addressed in a timely manner.

The provider had a complaints procedure in place but it was out of date. We saw that complaints had not always been appropriately responded to, if responded to at all.

The service was not well led. There were no adequate systems in place to ensure the service was safe, effective, caring, responsive and well led. There were no care plan audits, medication audits, environmental audits, infection control audits or adequate accident and incident monitoring in place to ensure people were safe and well cared for. All the policies and procedures we looked at were out of date and there was no evidence they were followed. At the end of our visit, we discussed the serious concerns we had about the service with the provider and acting manager. The provider and acting manager were unable to provide a satisfactory explanation as to why the issues we identified during our inspection had not been picked up and addressed.

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.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Safeguarding incidents were not appropriately investigated, reported and acted upon where necessary.

People's individual risks in the planning and delivery of care were not adequately assessed or managed.

Staff were not recruited safely. Staffing levels and the way staff were deployed 'on the ground' was unsatisfactory.

The way medication was managed and recorded was poor. The competency of staff to administer medication had not been checked.

Is the service effective?

Inadequate

The service was not effective.

Where people had mental health needs that could potentially impact on their capacity, the principles of the Mental Capacity Act 2005 and DoLs legislation had not been followed.

There was no evidence that staff were suitably trained or that their competency had been assessed. Staff had not received appropriate supervision.

People 's access to food and drink was limited and people's special dietary needs and risks were not managed.

Is the service caring?

Inadequate

The service was not caring.

Staff were pleasant in the brief interactions they had with people but we did not see any meaningful interactions between staff and people who lived at the home during our visit.

People sat for longs period of time without any staff interaction or meaningful activity to occupy their time.

We found that resident meetings and residents notices were not respectful or inclusive in the way they were conducted. Some of these notices displayed were derogatory.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were brief and did not accurately or sufficiently describe people's needs and care. There was little evidence of person centred care.

No social activities was provided to stimulate and interest people. The provider told us they could not afford to provide these.

The provider's complaint policy was out of date . People complaints had not been responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of effective monitoring systems in place to check the service was safe and of a good standard.

Policies and procedures were out of date and were not followed.

People had little opportunity to have an input into the service and express their views.

The culture of the home was institutional and not conducive to compassionate care.

Glenarie Manor

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 19, 20 and 21 September 2016 The first day of inspection was unannounced. The inspection was carried out by two Adult Social Care (ASC) inspectors and a Medicines Inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also contacted the Local Authority.

At this inspection we spoke with three people who lived at the home, the owner of the home, the provider, the acting manager, a nurse, three care staff, the maintenance person and the cook. We looked at a variety of records including five care records, eight staff files and training records, a range of policies and procedures, medication administration records and other paperwork relating to the quality of the service.

We looked at the communal areas that people shared in the home and did a tour of the home.

Inadequate

Is the service safe?

Our findings

We spoke with three people who lived at the home. One of the people we spoke with raised concerns about their care and the way they were treated by some of the staff at the home. During our visit we also had concerns about the way in which care was provided.

Daily routines implemented at the home by the provider meant people's ability to choose how they lived their life at the home was restricted. For example, people were only permitted to have food and drink in the dining room, only allowed to have drinks and snacks at permitted times and were only allowed a pudding on a Sunday. Some people at the home had raised concerns about their care and the conduct of some staff members but we found little evidence that the acting manager or provider had investigated these concerns in order to protect people from risk. We saw that people who lived at the home were often subject to disciplinary action if they failed to follow house rules. Disrespectul notices and information about people's behaviour and the way in which they lived at their lives at the home were circulated at resident meetings and displayed on notice boards in communal areas.

These incidences raised concerns that people who lived at the home were subject to institutional abuse. Institutional abuse is when people are subject to inadequate care or systematic poor practice that affects the entirety of their care.

We had serious concerns with regards to how the provider had come to manage people's personal monies. There were no systems in place to evidence people had consented to the provider controlling and managing their personal allowance and no adequate records in place to show how people's personal allowances were accounted for. When we asked the provider about this, they acknowledged no formal consent had been obtained and were unable to provide a satisfactory answer when asked about people's expenditure.

We spoke with three staff. They told us they had received safeguarding training but said that this was some time ago. Staff records did not demonstrate that staff were trained in how to safeguard vulnerable adults. We asked to see the provider's safeguarding records. We found them to be inadequate. They failed to demonstrate that the provider had responded appropriately and with empathy to people's concerns about their care and failed to show appropriate action had been taken in accordance with local safeguarding procedures in order to protect people from harm. The provider told us they had not received any formal training in safeguarding and were unaware of their legal duty to report safeguarding concerns to the Local Authority and Care Quality Commission.

These incidences were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have, and implement, robust systems procedures and systems that made sure people were protected from abuse and improper treatment.

Due to the serious and significant concerns we had about people's care, we referred all 24 people who lived at the home to the safeguarding team at the Local Authority. These concerns are currently being investigated by the Local Authority and the Police.

We looked at five people's care files and saw that no adequate assessment or care planning in respect of people's needs, risks and care had been undertaken. Risks were not properly assessed or explained to give staff an understanding of why the person was at risk and no risk management plans were in place to advise staff how to manage and prevent any risks from occurring. Some people were identified as at serious risk of self harm, suicide or challenging behaviour, but staff had no guidance on how to support or respond to the person should they display any signs of a mental health decline. People's daily logs showed that when people displayed challenging behaviours, agitation or distress, nursing staff did not always provide appropriate support.

This incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

The premises was well maintained, clean and a comfortable place for people to live. A maintenance person ensured that fire extinguishers, automatic fire door closures, fire alarm and emergency lighting checks were completed monthly. Water temperatures were checked to ensure they did not present a scalding risk but systems in place to monitor the risk of Legionella in the home's water system were not clearly described. It was unclear if the right checks were in place to ensure the risk of legionella was managed.

Safety certificates were in place for the home's passenger lift, electrical installation and moving and handling equipment but during our visit, we smelt gas in two different areas of the home. We asked to see the home's annual gas safety certificate and saw that it was a month out of date. This meant the provider could not be sure that the system was still safe.

We saw that Merseyside Fire Authority had visited the home's on 13 July 2016 and issued the provider with a notice of deficiencies in relation to the its fire safety provision. When we asked the maintenance person whether improvements had not been made, they told us that the provider had only just authorised the work to be done. This meant the provider failed to take timely action to protect people and staff from avoidable harm in the event of a fire.

These incidences were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was clean, safe and suitable for purpose.

We looked at eight staff files. We saw that staff were not always recruited safely or in accordance with the provider's recruitment policy. Some staff had been promoted or had changed job role without any evidence of a recruitment process. Some staff did not have previous employee references on file to demonstrate they had the skills and experience to care for people with mental health needs. Some staff had no criminal conviction check undertaken prior to employment or had not had their criminal conviction check renewed for over ten years. This meant the provider could not be assured that some staff were competent and safe to work with vulnerable people.

These examples demonstrate a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure that staff employed were of good character, and had the skills, qualifications and experience to work at the home.

We found that staff were not a visible presence in the areas where people sat. People sat for significant periods of time without seeing a member of the care team. Staff were seen to take frequent breaks instead of engaging with the people they cared for. A formal note from the provider to the staff team made

reference to staff taking 'customary naps' in the afternoon whilst they were working and for two hours on day three of our inspection, the provider disappeared without telling any of the staff team where they were going or how they could be contacted. We found staffing levels to be poor and staff deployment unsupervised and poorly managed.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to deploy sufficient numbers of suitably trained staff to meet people's needs.

Medicines were not managed safely. People did not always get their medicines correctly or when they needed them. The policies and procedures were out of date and did not reflect current NICE guidelines (Managing medication in social care – 2014). We saw that a controlled drug had not been recorded and destroyed in accordance with current legislation. The acting manager told us they did not know the medicine had been reclassified as a controlled drug in 2014.

Medication administration records poor. Some staff signatures to show when medication had been administered were missing from the records. This meant we were unable to tell whether these medicines had been given or not. The quantity of medication received into the home and carried forward from the previous month had not always been recorded and in some cases we were unable to determine how many tablets should have been present in the medication trolley. We found four different medicines in the trolley and medication cupboards that were out of date and unfit for use. Other prescribed medicines had had the dispensing labels removed, but had been kept for general use within the home. This is illegal. Medicines prescribed for one person must never be used for someone else.

Nurses did not have enough information to ensure 'as and when required medications' such as creams and painkillers were given correctly and in a way that met the individual's needs and preferences. This meant that people did not always get the full benefit from their medicines. We saw people were given their medicines, and had creams applied in the main office with little regard to their privacy and dignity.

Senior management confirmed that not all staff who handled medication had been trained and assessed as competent to do so. This placed people at unnecessary risk of harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the not all medicines were stored securely to protect people from risk and there was no evidence that staff who administered medication were trained and competent to do so.

Inadequate

Is the service effective?

Our findings

There was little evidence in staff files and training records that showed staff had received adequate or sufficient training to do their job. None of the care staff had received training in mental health despite supporting people with complex mental health needs and one staff member had been promoted from the role of domestic to support worker with no evidence that they had received any training in health and social care.

We asked the provider what training was available to staff to ensure they were able to meet people's needs. The provider was unable to tell us. The acting manager was also unable to tell us. We asked to see a copy of the provider's training schedule showing what training staff had received and when. The provider did not have one. The provider told us that staff training had not been provided regularly as they could not afford to train the staff. This meant the provider knew that staff team were not suitably trained to provide safe and appropriate care yet failed to take action to address this. This placed people at risk of harm.

We looked at staff induction, supervision and appraisal documentation. We found that the majority of staff had received inconsistent induction and support in their job role. None of the staff records we looked at showed that staff had received appropriate supervision in their day to day work or had an effective appraisal of their skills and abilities in the workplace. This meant the provider and acting manager had not properly checked to ensure staff were competent and safe to work with vulnerable people. It was clear that the provider and acting manager had not followed any of the provider's policies in relation to a skilled and trained workforce.

When we asked the provider who clinically supervised the acting manager in their role as lead nurse. The provider told us they did. When we asked if the provider had any clinical qualifications or experience in mental health care. They told us they did not. This meant they did not have the clinical skills and experience to safely or competently supervise the practice of clinical staff.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure staff received appropriate training, supervision and appraisal in their job role.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) to which DoLS relates is designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS is legislation that is designed to protect people under the MCA who may be deprived of their liberty and ensure that the least restrictive option is taken.

Where people had communication or mental health issues, their care plans contained little information in relation to their ability to communicate or how these difficulties impacted on their day to day. We saw that none of the people whose care file we looked at had their capacity assessed in relation to any aspects of their care. The provider and deputy manager confirmed this. Despite this, decisions had been made on their

behalf. This meant that the principles of the MCA and the DoLS legislation had not been followed and people's human right to consent to their care had not been respected or legally obtained.

We saw that one person's social worker had written to the home in September 2014 with regards to a deprivation of the person's liberty which they were concerned was "possibly illegal" as the principles of the MCA and DoLS legislation had not been followed.

An application to deprive this person of their liberty was subsequently submitted to the Local Authority. When we looked at the paperwork however we found that the provider and acting manager had again both failed to follow MCA legislation. No MCA assessment had been completed prior to the DoLS application. This meant there was no evidence that the person lacked capacity to keep themselves safe outside of the home.

There was no evidence that some of the people who lived at the home had consented to the provider having control over their personal finances. There were also no MCA assessments in place to show that the provider had assessed people's ability to consent to this decision. For some people, a personal allowance of £7.00 a day was given to them by the provider. We found no evidence however as to how the provider had decided upon this daily allowance, no evidence that this had been discussed with people and no evidence that the provider had regularly checked that £7.00 was sufficient for people's needs.

There was no evidence that the provider, acting manager or staff were trained in the Mental Capacity Act, the Deprivation of Liberty Safeguards or mental health care. This meant there was a risk that staff would not know how to care and support people with mental health conditions that impacted upon their day to day lives.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

People we spoke with told us the food was good at the home. One person said the "Food is lovely". We saw that there was a menu pinned up on the noticeboard in the dining room but on the day of our visit, what was on offer according to the menu was not what people received. The menu stated pork chop, cauliflower cheese and vegetables was to be served. What people received was a chicken burger on its own or a sandwich. We asked one person if they could have an alternative if they did not like what was being served. They told us "No I don't think so".

On looking at people's care plans, we found that people's dietary needs and risks had not been properly assessed which meant that staff had no clear guidance on how to meet people's nutrition and hydration needs. For example, two people whose care files we looked at lived with diabetes. Despite this no diabetic risk assessment had been undertaken and there was no guidance for staff to follow when preparing people's meals. There was also no information on potential diabetic complications for example if the person experienced a hyperglycaemic or hypoglycaemic attack [high and low blood glucose levels) or the action staff should take if such an attack occurred.

We spoke to the cook on duty on the day of our visit about people's special dietary requirements such as diabetes. They did not demonstrate that they knew who was on a diet controlled diabetic diet. This meant there was risk people would receive an inappropriate diet that placed their health and wellbeing at risk.

We saw that there was one person who lived at the home required a specific cultural diet. When we asked

the cook about this, their response was vague. The cook told us that the person rarely attend for meals in the home and if they did they were offered a salad. It was clear that no cultural dietary planning or consideration had been given to respecting this person's cultural needs.

We saw that one person's fluid intake required specific monitoring by staff in order to prevent serious health complications. There was no risk assessment or management plan in place in relation to this. We saw that there was a note in the person's file of when the person could have a drink but staff had no guidance on how much daily fluid intake was adequate or how much was excessive in order to ensure health related risks were managed. There were also no fluid intake records to monitor how much fluid had been given to the person, how much had been consumed or when the person had had a drink. This meant there were no system in place to ensure this person's hydration needs were safely met. This placed the person at risk of physical harm.

These examples were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure people's nutritional needs and hydration were met.

Inadequate

Is the service caring?

Our findings

People we spoke with had mixed views on how they were cared for. Two people told us they liked living at the home whilst another said that the home was like living in a 'Concentration camp'.

Staff spoken with demonstrated a knowledge of people's needs and behaviours. During our visit, we saw when care staff interacted with people they did so in a pleasant way but interactions between staff and people who lived at the home were limited. We did not see staff engaging with people who lived at the home in any meaningful way. Staff were task rather than people focused for example, setting the dining room table, helping to put shopping away as opposed to checking on people's welfare. Staff were observed to take frequent breaks were they sat together with cups of tea in the dining room or to read the paper.

People's ability to choose how they lived their life at the home was minimised. People were unable to take a drink or food up to their bedroom or into the TV lounge. They were only permitted to enter the smoke room one at a time and have food and drinks at certain times of the day and one person was given a deadline by which they had to 'attend' for breakfast. People's free will was limited and the way people lived was in the majority restricted by the regimes and routines prescribed by the provider. This did not demonstrate that the provider and the staff employed at the home cared about people's human rights to live freely.

We asked the provider whether any resident meetings took place. They told us they conducted resident meetings with people who lived at the home. The provider told us that the meetings were not well attended. We asked to see the records of the resident meetings. When we looked at the records we had serious concerns about the way in which these meetings were conducted. The records showed that in the majority, people who lived at the home were 'told off' for not adhering to house rules and there was no evidence that any of the people who lived at the home were encouraged or supported to share their views.

For example, two people were identified publicly by the provider during the resident meetings in October 2015 for not pulling the shower curtain around the shower cubicle fully when they took a shower. People who smoked outside but failed to put their cigarette stumps in the ashtray where told it was "Not rocket science" and we also saw that some behaviours which may have been linked to people's mental health condition were described as 'disgusting" with people advised that they would be charged for any additional support if there were 'found out' to be responsible for this behaviour. Records from the resident meetings were also openly displayed on the noticeboard in the dining room for all to see.

It was clear the provider had not cared how the tone of these meetings were conducted. It was clear they had not cared how people would feel being treated in this way or cared how people would feel when they were named in resident meetings. It was also clear they had given no consideration as to what impact this treatment would have on people's mental well-being.

When we spoke to the acting manager about the way in which the resident meetings were run. They acknowledged the the way in which the meetings were conducted were inappropriate and disrespectful to people and stated "It has to stop". One staff member who was concerned about people's care told us

"People here are a commodity"

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

Inadequate

Is the service responsive?

Our findings

The provider's resident handbook stated "The care we provide is based on a thorough assessment of needs and systematic and continuous planning of care for each resident". We did not find this to be the case.

Assessment information was inadequate and failed to provide staff with any background information on the person's mental health needs, current support requirements or preferences. People's care plans were not person centred and staff had no guidance on how to provide person centred care. Care plans contained little information about the person, their likes or dislikes or how they wished to be cared for. They lacked clear information about people's preferred daily routines, food and drink preferences or people's wishes with their day to day care. This meant it was difficult to tell if the person had been involved in the planning of their care and if so, what choices they had made.

When we compared what referral information the local authority or previous care providers had provided in relation to people's care we found that people's assessment information and care plans did not accurately or fully address all of people's identified needs, risks and wishes. For example, we saw that one person's previous care provider had supplied detailed information on the person's mental health needs, the signs and symptoms to spot in the event of a mental health decline and how best to support the person if their mental health declined. None of this information had been included in the person's care plan for staff to follow.

We saw that some people had challenging behaviours that placed themselves and others at significant risk if they were displayed. We saw from the daily records kept in relation to people's care that some people displayed these behaviours regularly or when they became distressed. There were no risks management plans or behavioural monitoring systems in place in relation to monitor and manage these behaviours. This meant staff had no guidance on how to support people who became distressed or diffuse potentially volatile situations in a person centred way. We also found that where people displayed challenging behaviour, people were often subject to 'counselling' or some form of punitive action by the provider.

For example, we saw that one person with complex mental health needs had damaged property at the home when they were distressed. Records showed that this person had been given a 'formal written warning' about their behaviour, a bill for the costs associated with the damage to the property and had been threatened with eviction if this behaviour continued to be displayed. When we checked the person's daily logs and a care plan however we found little evidence that this person had received any mental health support to manage their behaviour. There was no evidence that the cause of this person's emotional distress had been explored with the person, no evidence that any appropriate support from staff had been provided to the person to enable them to express their distress in a more constructive way or help the person deal with their negative emotions.

When we looked at people's care records we found no evidence that any of the mental health nurses employed at the home had offered or provided people with any form of recognised psychological support for their mental health needs. There was no evidence that people had consistent and meaningful support

from community mental health teams, social services or other professionals in respect of their care.

We asked the acting manager whether people at the home had access to recognised psychological therapy in order to promote their mental health either on an individual or group work basis. They told us no recognised therapies were used at the home. They told us people were 'counselled' when they needed it for example, after an incident of challenging behaviour but when asked, the acting manager was unable to tell us what recognised form of counselling this was or describe in any detail how these 'counselling sessions' were structured.

There was no evidence that care plans had been meaningfully reviewed with the person and any associated healthcare professionals or the person's representatives. The majority of reviews stated 'no changes' or were simply a copy of the previous care plan with the date changed. This did not demonstrate that people's care was regularly reviewed to ensure staff had clear and up to date information on people's needs and care.

These examples demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to design and deliver care which was appropriate, met people's needs and ensured their preferences.

The home catered in the majority for younger adults with complex mental health conditions. The provider's resident handbook promoted a programme of rehabilitation wherein people could regain life skills such as cooking their own meals, in preparation for them to move out of the home into their own accommodation. When we looked at people's care plans they failed to clearly outline the tasks people could do independently and what they required help with in order to provide clear guidance on what rehabilitation support the person required. There was also no documented rehabilitation programme in place or organised daily activities to enable people to regain life skills in any effective way.

We saw that the home had a small rehabilitation kitchen, but on each day of our visit the kitchen was locked at all times. We asked two staff members about this who told us the rehabilitation kitchen was never used. They told us that people were not permitted to use the kitchen to make a drink or a snack. We asked the acting manager if the rehabilitation kitchen was in use, the acting manager confirmed the kitchen was not used to enable people to regain life skills.

We saw that there was a laundry list pinned up on the noticeboard in the dining area. We asked a staff member about this. They told us each person was expected to do their own laundry and ironing and were given a set day when they could use the laundry and the iron. They told us they supported people to do this when necessary.

We asked the provider why people were expected to do their own laundry and ironing but were not permitted to make their own drinks and snacks. There are risks associated with vulnerable people handling detergent, operating electrical equipment and hot surfaces that could cause serious injury in the same way that there are risks associated with people making their own drinks and snacks. The provider was unable to provide a satisfactory explanation.

We saw the provider's resident handbook advised that "a range of activities which enables each resident to express themselves as an individual" will be provided.

We asked the provider and acting manager what activities were provided for people who lived at the home to meet their social and emotional needs. The acting manager told us some people at the home attended a

health group at a local venue but other than that there were no activities on offer. They told us that people got upset if activities were suggested. We saw no evidence that any activities had been planned, suggested or discussed with service users or that the planning of activities had had any detrimental effect on people's health and wellbeing. When we asked one of the service users if they would like activities to be provided, they told us they "Would give them a go".

The provider told us that people who lived at the home had access to the games room which contained a dart board, pool table and book shelf and the TV lounge but acknowledged no other activities were provided. On each day of our visit, we found that the games room was rarely used, staff were not observed to encourage people to have a game of pool or darts and for the majority of our visit people sat in the communal lounge watching the music channel or outside smoking.

One staff member told us the reason no activities were provided was because "The management don't want to do them".

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to ensure people who lived at the home were treated with dignity and respect. They also failed to ensure that people's autonomy, independence and community involvement were supported in line with their needs and preferences.

We reviewed the information given to people by the provider in relation to how people could raise concerns or complaints about the care they received. We saw that the provider's complaint policy lacked important information about who people should contact to make a complaint and contained inaccurate information in relation to organisations outside of the home, that could assist people with any complaints or concerns they had.

We found that one person had made written complaints to the provider about their care. We saw that some of these complaints had been responded to, but not others. When we looked at this person's complaint records we found no evidence that this person's concerns had been taken seriously, listened to or properly investigated. We spoke to the provider about this who acknowledged they had not investigated or responded to some of the person's complaints.

One complaint related to the conduct of the previous registered manager. We noted that this complaint had been responded to by the previous registered manager themselves and not the provider. This raised concerns about the appropriateness and objectivity of any complaint investigation.

One concerned staff member we spoke with told us "Residents have complained here and they have just laughed at them".

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have an effective system in place to record, handle and respond to people's complaints and where complaints had been received had failed to investigate and take proportionate action.

Inadequate

Is the service well-led?

Our findings

During our visit, the provider told us that they did not own the home and that it was owned by another person. This was not known to The Commission prior to our visit and had not been previously declared. We had concerns that the owner of the home was not registered with The Commission as a 'registered person'. We spoke to the provider about this and expressed our concerns. The owner was intermittently available in the home throughout our visit.

At the time of our visit there was no registered manager in post. The previous registered manager resigned from their position in June 2015 and now worked at the home as a bank nurse. The current acting manager had subsequently been appointed but had been off work for a period of time following this appointment. The provider told us this had meant there was a delay in applying for their registration as registered manager.

We saw that the provider was heavily involved in the day to day running of the home and the delivery of care. The acting manager told us they had little control with regards to how the home was managed. We drew to the acting manager's attention to the concerns we had with regards to the way in which people were treated at the home. The manager told us that the provider "Kind of dismisses things when you challenge them". They said the provider "Takes control of everything".

We saw that the acting manager had no computer, printer, photocopier or fax to use in the operation of their duties. We asked the acting manager if they had spoken to the provider about this. They told us that they had but the provider was reluctant to purchase the equipment. They told us that the provider had an office upstairs which contained this equipment but only the provider had a key and they "Wouldn't have it any other way". They told us they were unable to get into the provider's office when they were not in the building. We asked the provider about this, they told us they could not afford to buy this equipment. This meant that the acting manager had no equipment to enable them to properly fulfil their managerial duties.

We checked what systems the provider had in place to manage the health, welfare and safety risks posed to people who lived at the home. We found no adequate systems.

Care records relating to people's care had not been audited to check they were accurate, up to date and sufficiently detailed. The provider and acting manager acknowledged they did not undertake any care plan audits to ensure people's care was properly planned for and delivered. When we asked the acting manager about this, they told us they had "Never really heard of a care plan audit". This meant that the inadequacy of people's assessment and care planning information had not been picked up and addressed. This placed people at risk of inappropriate and unsafe care.

We found that the way in which medicines were managed at the home was unsafe. We asked the provider and acting manager how they checked that medications were managed safely. The provider and acting manager acknowledged there was no system in place with regard to medicines management. This meant that concerns we identified during our visit, had not been picked up and addressed. This meant people

were not protected against the risks associated with the use of medicines.

We saw that accident and incident records were completed when an accident or incident occurred. When we asked if there were any monitoring systems in place to monitor trends in the way accidents or incidents occurred we were provided with a hardback book which contained a brief summary of the accident and incident. This information was meaningless as it was not analysed in any way to see if there were any similarities in the way in which accidents or incidents occurred so that they could be prevented in the future. The provider acknowledged accident and incident information was not used in this way. We also found that accident and incident records did not always correspond to the entries made in the hardback book.

The provider had no systems in place to assess and regularly monitor the sufficiency and competency of the staff on duty and had no clear knowledge of people's needs and risks when asked. During our visit we found staffing levels, the training and support of staff and their deployment poor. This placed people at risk of ineffective and inappropriate care.

There were no infection control audits, no regular environmental audits and no audits of the provider's policies and procedures to ensure they remained up to date and in line with current legislation.

We found that there were limited opportunities for people to feedback their views on the quality of the service provided. Resident meetings were not well attended and the focus of these meetings was not conducive to encouraging people to share their views and ideas on the running of the home. We asked the provider if people's satisfaction with the service and life at the home was sought. They told us that they had tried to do a satisfaction questionnaire but that people who lived at the home would not fill them in. They said that people had wanted care staff to complete it with them. The provider said that they did not want that as it would then be in the "care workers words". This meant that there were no systems in place to gain people's feedback to enable the provider to come to an informed decision about the service provided.

During our visit we found the culture of the home to be regimented and authoritarian both in relation to people who lived at the home and the staff employed to work there. The way in which the home was managed lacked transparency and staff lacked positive role models in compassionate and person centred care.

The service was not well led. It was not safe, effective, caring or responsive in relation to people needs or care.

These incidences were a breach of breach of 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to identify, assess and manage the risks relating to the health, welfare and safety of people at the home.