Bupa Care Homes (CFHCare) Limited

Monmouth Court Nursing Home

Inspection report

Monmouth Close
Ipswich
Suffolk
IP2 8RS

Date of inspection visit:
15 December 2015
17 December 2015

Date of publication:
14 April 2016

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

Monmouth Court Nursing Home provides care and support to a maximum of 153 older people, some of whom were living with dementia and/or had complex nursing needs. People were accommodated across three units, with a fourth unit being closed at the time of our inspection. At the time of our visit there were 101 people using the service.

The inspection was unannounced and took place over two days, on the 15th and 17th December 2015.

The home had a registered manager in place. 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 requirements in the Health and Social Care Act 2008 and associated regulations about the service is run.

We identified significant shortfalls in the care provided to people across all three units at the home. This was linked to a lack of oversight from the registered manager and provider.

Relatives raised concerns about people's safety. People were put at risk of harm because care records and assessments did not clearly reflect all current areas of risk and how these should be managed to protect the person from harm. Staff were not proactive in reducing the risks to people and so they were left without appropriate support. For example, when they were anxious or unable to do something independently.

Medicines were not managed and administered in a way which ensured people's safety and did not reflect best practice in some areas.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Staff were unable to demonstrate that people were appropriately supported when they were unable to make choices about their lives.

People were not consistently supported to live full and active lives, and to engage in meaningful activity within the service. We saw people who were socially isolated with little or no action taken by staff or the manager to address this.

Care planning for people was generic and not person centred. In addition care planning wasn't written in a way that helped staff to understand people's experiences or interests prior to moving to the home. People and their representatives were not involved in the planning of their care, and their views were not reflected in their care records.

People told us and we observed that there were not enough suitably trained and experienced staff available to meet peoples social, emotional and physical needs. Staffing levels were not calculated by the management based on the needs of people using the service.

Staff were not consistently supported to develop their skills within the caring role. There was no system in place to assess staff competency and performance. Supervision of staff was not consistent.

Systems in place to monitor the quality of the service were not effective in identifying shortfalls and areas for improvement. There was not an open culture within the service. Staff told us they felt there was a disconnect between them, the registered manager and provider. People and their representatives said that although they were invited to residents meetings, issues raised in the meetings were not acted on by the manager so improvements were not made.

People told us they knew how to make a complaint but didn't feel they would be listened to. It wasn't clear how complaints were used to improve the service.

Throughout the two inspection visits we identified such serious concerns that we immediately fed these back to the Registered Manager so action could be taken to protect people from harm. In addition, we shared information about the concerns we identified with the local council's safeguarding team and local commissioners. Following the inspection, we wrote to the provider to request information about how they intended to make the urgent improvements required to protect people from the risk of coming to significant harm. We also took urgent action to stop this home from admitting anyone new by amending their conditions of registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not identified, planned for and managed appropriately.

Medicines were not managed and administered safely.

There were not enough staff available to meet people's needs..

Is the service effective?

Inadequate

The service was not effective.

The service was not complying with legislation around the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People had a choice of food and drink that met their needs, however, people were not appropriately supported to maintain good nutrition and hydration.

Staff received appropriate training for the role, but staff competency was not monitored and issues were not identified.

Staff did not receive appropriate supervision and appraisal for the role.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always interact with people in a kind, caring and compassionate manner.

Positive relationships were not always formed between people using the service and the staff supporting them.

Staff did not uphold the dignity and respect of people using the service.

A culture of kindness and compassion was not promoted by the

service.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always have access to appropriate stimulation and activity and were not supported to live fulfilled lives.

People and their representatives were not involved in the planning of their care.

People's care records were not person centred, and did not reflect people's preferences.

People had the opportunity to feedback their views at meetings and knew how to complain about the service. However, it was unclear how people's views were acted on.

Is the service well-led?

Inadequate

The service was not well-led.

A quality assurance system was in place; however this was not capable of identifying shortfalls in the service.

The culture in the service was not open, transparent, honest and positive.

Monmouth Court Nursing 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 over two days on the 15th and 17th of December 2015 and was unannounced. The inspection team was made up of three inspectors, a pharmacy inspector, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we examined previous inspection records and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We spoke with 27 people who used the service, nine members of care staff, the manager and the deputy manager. We looked at the care records for 19 people, including their care plans and risk assessments. We looked at staff recruitment files, medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service.

Inadequate

Is the service safe?

Our findings

People were not safe because risks to them had not been fully identified and planned for. A relative of one person told us, "[Relative] is left to their own devices. Always falling over, staff nowhere to be seen. I really worry about [relatives] safety when I'm not here to help. It keeps me up at night." We identified that one person had fallen 59 times in a ten month period. Records showed the person had incurred several injuries from falling and had required medical attention as a result. We observed that staff were not supporting the person to reduce the risk of them falling. For example, their risk assessment stated they should be encouraged to use their walking aid and have it near them at all times. However, we observed several times that the persons walking aid was not within their reach to enable them to use it. This put them at a continuing risk of falling and seriously injuring themselves. We discussed this with the Registered Manager who was unaware of the number of times this person had fallen and they could not demonstrate to us that any action had been taken to protect this person.

Another person's care plan stated they were at a high risk of falls and required reminding by staff to use their walking aid to reduce the risk of falls. However, observations showed that staff did not encourage them to use their walking aid. We had to intervene during the inspection when the person became unsteady and fell against the wall. There were several members of care staff in the vicinity who did not come to the person's aid, so we supported the person to steady themselves. A staff member brought their walking aid over, but placed the aid the wrong way round and left without speaking to the person. The person then walked off without the walking aid, and neither the staff nor the unit manager made any attempt to remind the person or change the aids position, leaving the person at a continued risk of falling and seriously injuring themselves.

Prior to our inspection an incident had occurred where a person had left the service unnoticed. Staff were unable to tell us how this incident had occurred. The person's care records showed that the risk of the person trying to leave had been identified prior to the incident. To minimise the risk it was recorded in the persons care records that they required constant supervision by staff. However, there was no further detail of how this was to be organised. Thirty minutes had passed before staff realised the person was missing. The service did not learn from this incident and we saw that effective management to reduce the risk of the person leaving unnoticed again was not in place. The Registered Manager was unable to demonstrate that they had oversight of this situation to ensure the person's safety and wellbeing was effectively managed.

An assessment of risk from bed rails had been carried out for seven individuals. Bed rails are used to reduce the risk of falls from a bed. However, there are hazards associated with their use. The outcome of the assessment for each of those individuals indicated the bed rails could potentially cause harm and this meant alternative methods should be considered. Despite this outcome, staff were unable to demonstrate that alternatives had been considered or tried. One person had sustained an injury that required medical attention as a result of getting their leg stuck between the bed rails. During our inspection visits we observed this person lying in their bed with their legs hanging over the top of the bed rails which placed them at risk of reoccurrence of this injury. The risk had not been reassessed and no action had been taken to prevent further injury. We brought this to the attention of the Registered Manager on the first day of our inspection

and no action had been taken by the second day of our inspection.

Where people had been assessed as being at high risk of developing a pressure ulcer, control measures were not put in place to reduce the risk. Information about what support people needed to maintain their skin integrity was not included in their care records. Where it was recorded in their records that people required repositioning in bed, it was not stated how often this should happen. Records did not reflect that the person was being regularly repositioned in order to reduce the risk of them developing a pressure ulcer. For example, one person had been admitted to the service with a grade four pressure ulcer. There was no detailed care planning in place which set out how staff should support the person with this. It did not state in their care records if they should be repositioned, and if so how often. The person was unable to reposition themselves independently. We spoke with the staff member in charge, who said the person should be repositioned "about two hourly." The records for this person were not being completed and therefore staff could not demonstrate they were being repositioned regularly enough to protect them from the risk of further skin breakdown. We shared this information with the Registered Manager so that action could be taken to protect this person.

It was unclear how people coming to the end of their life were supported to remain comfortable. One person had been admitted to the nursing unit for palliative care six days before our visit. However, the person only had a brief 'short stay care plan' in place which did not set out their needs and how they should be met in sufficient detail. There was no information about how the person should be supported to remain pain free, and what their wishes were at the end of their life. Information on discharge from hospital stated the person required oxygen. However, this was not recorded in the persons care plan and was not in place at the service. Similarly, the continuing care document stated they required support to eat. However, their overall care plan stated they did not.

We noted that the person's Waterlow score had been calculated incorrectly as 12, when it totalled 24. A score of 24 means the person is at significant risk of developing a pressure sore. No action had been taken to address this risk. This was discussed with the staff member in charge as well as the Registered Manager so that action could be taken.

People were not being protected against the risks associated with medicines. Medication records did not always confirm that people were receiving their medicines as prescribed. Nursing staff told us there were weekly checks in place but confirmed that the checks had not identified the discrepancies.

There were charts to record some people's blood glucose levels; however, there were gaps in these records. We found that records of scheduled blood tests for people prescribed the anticoagulant medicine Warfarin were not kept up to date so nursing staff could not refer to the most recently prescribed dosage schedule following the tests when administering a person's Warfarin. When people were prescribed medicines on a 'when required basis' (PRN), there was written information available to show staff how and when to administer these medicines. We noted the information was not regularly reviewed and it lacked detail when medicines were prescribed this way to manage people's psychological agitation. In addition, when these medicines were used, records did not show the reasons why they were needed. Therefore people may not have had these medicines administered consistently and appropriately.

In areas where people were living with dementia, medicines prescribed for external application were not safely stored so people were at risk of accidental harm by accessing and ingesting them. Medicines requiring refrigeration were not always being stored at correct temperatures so may no longer have been safe for use. Issues with medicines were raised with staff in charge of administering medicines as well as the Registered Manager on the first day of our inspection. However, action had not been taken to mitigate these risks by the

second day of our inspection.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People and their relatives told us there were not enough staff available to meet their needs. One person said, "They do their best but I always have to wait. There's so many of us and so little of them. What do you expect?" Another person told us, "Staff are hard to come by here. Try and do my best on my own, I know I'm a burden and they don't have time." One other person commented, "They are rushed off their feet, can't do no more. I go hours without seeing anyone sometimes." A relative said, "I have a lot of worries about the staffing numbers. Sometimes I come in and just wonder how they can even manage to look after everyone." Another relative told us, "There is never enough. Some days are worse than others."

There were not enough staff to ensure timely and appropriate help was given to support people during meal times. For example in one unit there were seven people who required support to eat seated in the dining room, another person (who required encouragement) seated in the lounge and 10 people, some also requiring assistance received their meals in their bedroom. There were three care staff serving and assisting people in the communal areas and two serving meals to those in their rooms. We observed that people were rushed to eat their meals, with staff spooning food into their mouths before they had finished the previous mouthful. Staff told us they struggled at meal times to meet everyone's needs. One said, "Today is a good day, relatives are here to help but usually it would just be us. It's a struggle."
It was unclear who was in charge of the units when the team leaders were not present. We observed that the management and deployment of staff was chaotic, and this meant that people's needs were not met consistently. We spoke to staff about the management arrangements in place. One staff member said, "When the team leaders here [they are] in charge. When they aren't, no one's in charge really. Just do what you think."

When we discussed issues in staffing levels with the Registered Manager, they told us that staffing levels were based on the number of people using the service, not on the individual needs of the people using the service, which could be varied. The Registered Manager had no system in place to monitor the staffing level to ensure that people's needs were being met or review how the staff were deployed to see if improvements could be made.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

There was a robust recruitment procedure in place to ensure that prospective staff members had the skills, qualifications and background to support people.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.
People were put at risk of having their rights and liberties restricted unlawfully because the service was not following legislation around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People told us that staff did not always ask for their consent before carrying out care. One told us, "They just busy about, they forget it's up to me." Another said, "I don't feel like they ask my consent, no. I don't always feel like I have a choice, I just get on with it."

People's care records contained 'best interests care plans' which were inappropriate, and instructed staff to complete care interventions which were not carried out in line with the MCA and DoLS. For example, one person's care plan stated they often refused care interventions such as blood tests and instructed staff to physically hold the persons arm down so the blood test could take place. We spoke to staff about this, who confirmed this is what they did if the person refused. The service had not followed a formal best interests process to decide whether these restrictive interventions were necessary and in the persons best interests. This meant that this person was potentially being unlawfully deprived of their right to refuse care and treatment. We raised this with the Registered Manager immediately who did not have an understanding or awareness of why this was inappropriate. We asked the Registered Manager to ensure this practice ceased until the appropriate process had been followed in line with legislation.

People were being administered medicines covertly without the service having first followed the appropriate best interest's process in line with the MCA and DoLS. The service had not given consideration to the person's capacity to refuse medicines or whether administering medicines to them without their knowledge was both in their best interests. This was discussed with the staff in charge of administering medicines who did not understand why this was inappropriate and needed further assessment. Action was not taken between our first and second inspection visit to ensure that people were not administered medicines covertly until the proper process had been followed in line with legislation.

This was a breach of Regulation 11: Consent to Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People were not supported to maintain healthy nutrition and hydration. Meal times were chaotic, and people were served their meals in an ad hoc manner. Meals were served by staff and removed by other staff which meant it was difficult to identify when people hadn't eaten much. People were not given a choice of

where they wished to eat, and there were not enough seats in the dining room to accommodate everyone. One person was clearly disorientated at having been served their meal in the living area and refused to eat. The person kept saying "There's no room for me to sit in [dining room]." Three other people were sat at the dining table in chairs that were too low and meant they could not reach their meal or drink easily.

People did not receive the support they required from staff to eat their meals. We observed one person struggling to eat for some time and when they stopped trying; their meal was taken away from them and no assistance or encouragement was given. Two people were asleep and their meal had gone cold without them having eaten any. Staff removed the meal without attempting to prompt the people to eat and there were no arrangements made to ensure they were offered their meal at a later time. The care records for these people showed that they were of a low weight and at risk of malnutrition. We observed another two people who waited in excess of 35 minutes for their meal which was served after everyone else had eaten. We were told by staff that they had run out of food and had to cook more.
We saw poor practice when a staff member gave one person a few mouthfuls of food then took the meal away. The person had a low weight and was at risk of malnutrition. Their food and fluid intake was not being monitored to ensure it was sufficient, and the nurse in charge told us this was because "[person] doesn't eat much anyway so there is no point recording it." The nurse could not tell us what action had been taken to protect the person from the risk of malnutrition, such as referring the person to a dietician for advice or offering the person other foods throughout the day. The care plan did not reflect if any action had been taken. We spoke to the person about why they didn't eat much of their meal and they told us "Well it's difficult to eat when you can't see it and no one helps you."

The food and fluid intake of other people using the service was not being monitored where they had been assessed as at risk of malnutrition. This meant that the service could not identify early signs which may indicate the person required more support to eat or input from a professional. Where people were identified as at risk of malnutrition, they were not weighed often enough for the service to quickly identify and put in place any intervention to avoid further deterioration. Staff and the Registered Manager were not clear what action had been taken where people lost weight. This therefore placed them potentially at further risk of harm.

This was a breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Poor staff practice that put people at risk was not identified and addressed to protect people from harm. Staff received regular training in key competencies relating to the caring role. However, staff performance was not monitored to ensure that the training they received had been effective. Issues with staff performance and culture had therefore not been identified by the management of the service. Staff did not receive regular meaningful supervision or appraisal which focused on their development within their role. Staff told us they did have supervision with their managers, but that these were "very infrequent" and they said they "didn't see the point in them."

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.
It was unclear how the service supported people to have appropriate access to external healthcare professionals such as GPs and dieticians. For example, where a referral to the dietician would have been appropriate for someone with unexplained weight loss, staff could not demonstrate that this referral had been made. When a referral had been made, it was unclear what the outcome was, or what advice had been obtained. Where people had been prescribed medicines such as antibiotics by their GP, it was not documented in their care records what the medicine was for or why it had been prescribed to enable staff to

monitor effectiveness. When people had sustained an injury from an accident such as a fall, staff could not always demonstrate they had obtained advice from healthcare professionals in a timely manner. A relative told us, "I had to ask three times for [relative] to see the doctor. I knew [relative] wasn't right but I was totally ignored."

This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

There were widespread and significant shortfalls in the service which meant people's immediate needs and their ongoing wellbeing did not benefit from a caring culture. Whilst some staff had good intentions, they were not supported by the overall management of the service to ensure that people were consistently treated with kindness, compassion and respect. We observed that staff often spoke about people in a task focused manner which was disrespectful and lacked empathy for the person or their situation. For example, we overhead one staff member loudly say to another "can you go and toilet [person] before [person] wets themselves." The language used to describe people's needs in their care records also did not reflect a caring, kind and respectful attitude. One person's care record stated "[Person] does things deliberately to get attention. Ignore these behaviours." People's privacy and dignity was not always upheld. For example, we observed a staff member carrying out personal care without first speaking to the person to explain what was happening and without closing their bedroom door to protect them from unwanted view. We observed other staff members wheeling people who were asleep in their chairs to other rooms or locations without first attempting to explain what was happening, speak to them and orientating them to their surroundings.

People were not always spoken with in a kind and caring way and staff did not always show appropriate concern for their wellbeing. We observed one person ask for support from staff a number of times over a period of twenty minutes without success. When they asked again the staff member said "Look, you've already asked six times. I'll get to you when I have time." This interaction was not caring and did not make the person feel as if they mattered.

Consideration had not been given to support people's dignity. For example, at meal times plate guards or assisted cutlery were not offered or in use which would have benefited some people in maintaining their independence and dignity. When support was given it was not always delivered in a dignified and respectful way. One person required assistance to position themselves to eat, and when a staff member saw that they were struggling the assistance was provided roughly. The staff member then stood over the individual and spoon fed them in a rushed manner; they became frustrated because the individual was taking their time to eat their mouthful and took the meal away without asking them if they had finished. We immediately reported this poor practice to the registered manager and we were given assurance that the incident would be investigated.

People and their representatives were not involved in the planning of their care. Care records did not reflect peoples preferences with regard to how they wanted their care delivered. Relatives told us they were not asked for their views or involvement in care planning. One told us, "I don't know anything about [relatives] care planning." Another said, "I didn't know I should be involved. I don't know what care [relative] has."

These instances of poor practice were raised with the Registered Manager on both our inspection visits. Poor practice was also shared with local commissioners and we raised safeguarding concerns with Suffolk County Council where we felt people were at risk.

This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2010 (Regulated

Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People's care records were generic and not person centred, often containing the same information for each person. There was limited information available about people's likes and dislikes, preferences and choices or their hobbies and interests. One person said, "They don't know me or what I'm about, but why should they I suppose?" A relative said, "[Relative] has been here for ages and the staff still ask me things they should already know. I wonder what they do when I'm not here. It worries me." This meant that people were not provided with care centred on them as an individual.

Personal life histories for people living with dementia were limited. The information had not been explored with families to support staff to understand their personal and individual needs with regards to how dementia affected them in their day to day lives. Access to this sort of information would enable staff to provide more personalised care or help develop ways to engage with each individual in a meaningful way.

People were not being protected from the risks of social isolation and loneliness. Staff did not support people with individual interests or hobbies and there was no system to ensure that people who spent time alone had this explored through individual care planning to ensure their needs were met. Whilst there was a member of activities staff available in the communal living area during the day, people were not consistently supported to live full and active lives. For example, individuals only had the opportunity to take part in organised group activities such as playing games. Staff couldn't tell us about how people liked to spend their time or how they supported them to live a fulfilled life. Staff felt that this was the job of the activities staff and not a responsibility of theirs. One said, "There's activities staff for that, we don't get involved in that side of things." Staff failed to take opportunities to further understand the lives of those they supported or recognise how this was an important part of their role which impacted on the persons experiences of the day. We observed that people who stayed in their bedrooms did not receive regular interaction from staff, nor were they engaged in activity. Many people were sitting in their bedrooms with not even a basic source of stimulation such as a television or radio. People told us they were bored. One said, "I don't get up to much. Not much to do is there." Another said, "What's the point, I feel like I'm at the end of the line anyway. I can't do anything I enjoy anymore." A relative also raised concerns saying, "Everyone always just seems to be sitting around, never doing anything. It's sad."

We observed one person sitting in the living area for three hours who slapped their head repeatedly and were calling out throughout this time. The person was not engaged in any activity, but had been given a book which they were not looking at. They threw the book on the floor at one point, and a staff member removed it without speaking to the person. It was clear the person wanted the attention of staff, as on the brief occasions they did receive staff attention they were much happier. When we looked at the person's care records no assessments had been made to look for ways for the person to spend their time which would stimulate and engage them.

People and their representatives were invited to 'residents' meetings where they could express their views. However, it was unclear how people's views and suggestions were considered and acted on by the management. Meeting minutes did not reflect the specific suggestions people or their representatives had

made and the registered manager was unable to tell us if any views or suggestions provided had been acknowledged or addressed. Relatives told us they didn't feel as if changes were made as a result of what they said. One told us, "I attend every meeting but we never get explanations for why things we said last time didn't get done." Another relative said, "I think it's a paper exercise. I go but I don't see the point as [manager] just sits there listening but doesn't do anything later on. As if it's just forgotten." The manager was unable to show us any other method of obtaining the views of people using the service, for example, through an anonymous survey of their views.

This was a breach of Regulation 9: Person centred care of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People and their representatives told us they knew how to make complaints, but some felt that they wouldn't be listened to. One relative said, "You know what, I've made complaints. I'm always complaining. Do things ever change? No." Another relative told us, "I know how to make a complaint, yes. Whether there's any point in doing so is another matter. I don't think it would be taken seriously." A person using the service commented, "I don't feel comfortable speaking up." Another person told us, "I sometimes have a moan. No one has ever come to talk to me about it though." We looked at the records of complaints that had been made, and how these were investigated. It was not clear what the outcome of these investigations were or how they were used to improve the service. The manager could not demonstrate how complaints had been used to inform the future development of the service.

This was a breach of Regulation 16: Receiving and acting on complaints of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The registered manager and provider did not have effective oversight of the quality of the service. When we commenced our inspection, the registered manager told us that we would see "significant improvement" from the previous inspection. However, outcomes for people using the service were poor and when we shared the concerns we found they were not aware of them. Quality monitoring processes were ineffective and did not identify the shortfalls which put people's health, safety and welfare at risk. For example, an audit of the service carried out by the regional manager and quality manager in November 2015 did not identify any of the serious concerns we identified during our inspection visits. This exposed people to the continuing risks associated with receiving poor care. This included, but was not limited to, audits of risk assessments and medicines. Some internal audits were carried out by different staff members on each of the three units, but the registered manager had no system in place to check whether these were being carried out effectively to identify and address shortfalls. There were inconsistencies in the frequency of these audits across the three units and there was no system for monitoring the impact of any changes as a result of feedback learning and development from best practice.

Each of the three units were managed by a team leader with limited oversight by the registered manager. There were differences in how the team leaders ran the units. For example, on one of the units team meetings were carried out with staff regularly, and on the other units these took place very infrequently. Some staff received consistent support from their team leaders, whereas others said the support they received was "non-existent". The registered manager told us it was up to the team leaders how they ran their units, and that there was no system in place for them to monitor how the team leaders did this. A staff member told us, "[Registered manager] is quite hands off. We are managed by the team leaders, I don't really have anything to do with [registered manager], and I wouldn't go to [them] if I had a problem."

The overall culture across the service was not open and inclusive. Staff were not consistently given the opportunity to feedback their views and were not involved in the continual development and improvement of the service. Meeting minutes didn't demonstrate staff could use them as an opportunity to discuss performance or changes to the service. Staff told us that they didn't feel involved in things. One said, "We don't get told anything. I know my place." Staff said they didn't feel comfortable raising concerns with the registered manager, and would not go to them if they had an issue. One said, "[Registered manager] isn't someone who would help me with my problems." Another told us, "[Registered manager] is probably the last person I'd go to here for help."

Feedback from relatives and minutes of relatives meetings showed that the meetings were not proactive and definitive actions were not carried forward to drive improvement in the quality of service delivered. There was no feedback to people and/or their relatives in response to issues that were raised.

Incidents and accidents were not analysed to identify any trends or themes with an individual or across the service that could be addressed and improved. Learning had not been taken forward with the care team from these events to ensure they were not repeated and future incidents less likely to occur. For example, the service had not identified incidences of falls and an put in place an action plan to reduce these and

protect people from harm.

Following our first inspection visit on the 15th of December 2015, immediate and prompt action was not taken by the management to safeguard people we had raised concerns about. When we returned on the 17th December 2015 we found people remained at serious risk and that shortfalls in their care had not been addressed urgently as was required. This meant we had serious concerns about the ability of the management to bring about prompt and meaningful improvements to keep people safe.

We shared information with the safeguarding team at the local authority so that we could work in a joined up way to ensure people were immediately protected from further significant harm. In addition, we wrote to the provider to request information on how they intended to make the immediate improvements required.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9.— 1.The care and treatment of service users must— a.be appropriate, b.meet their needs, and c.reflect their preferences.

The enforcement action we took:

Urgent NOD to suspend admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent 11.— 1.Care and treatment of service users must only be provided with the consent of the relevant person.

The enforcement action we took:

Urgent NOD to suspend admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12.— 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.assessing the risks to the health and safety of service users of receiving the care or treatment; b.doing all that is reasonably practicable to mitigate any such risks;

The enforcement action we took:

Urgent NOD to suspend admissions

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs 14.— 1.The nutritional and hydration needs of service users must be met. 2.Paragraph (1) applies where— a.care or treatment involves— the provision of accommodation by the service provider, or an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or b.the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.

The enforcement action we took:

Urgent NOD to suspend admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17.— 1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a.assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

The enforcement action we took:

Urgent NOD to suspend admissions