The Shrubbery Nursing Home Limited

The Shrubbery Nursing Home

Inspection report

Birmingham Road
Kidderminster
Worcestershire
DY10 2JZ

Tel: 01562822787

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 August 2017 and was unannounced. The inspection was completed in response to concerns from a member of the public about people's safety. At the last inspection in January 2017 the service was rated as good. At this inspection we found the service was inadequate overall, and in the key questions safe and well-led. The inspection identified six breaches of regulation.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
The Shrubbery provides personal and nursing care and accommodation for up to 39 older people. There were 29 people who were living at the home on the day of our visit.

The registered manager had resigned from their post in June 2017. At the time of our inspection an interim manager had been in post since the 17 July 2017. 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.

People were not fully protected from harm and abuse. Where incidents of abuse had occurred the provider

had failed to take the necessary action to report this as staff had not followed safeguarding protocols and incidents had not been reported to external agencies. Measures that the provider had put in place to protect people were not adequate, and people had experienced further incidents of abuse. The provider had not identified potential risks and put plans into place to protect people from further harm. The provider contacted relevant authorities at CQC request, which had been accepted for investigation by the external agencies.

People were not supported to have maximum choice and control of their lives. We saw an example where staff had not worked with the person or their family member's to make decisions about a person's care that was in their best interest. We found the care the person received was restrictive and the provider had not considered the person was being subjected to a Deprivation of liberty (DoL). Staff's training was inconsistent, their knowledge and understanding were not checked by the provider to understand if staff were delivering high quality care. People were supported to eat a healthy balanced diet and with enough fluids to keep them healthy. People had access to healthcare professionals when they required them.

Some people told us that staff did not always treat them kindly when they called for assistance or asked for support. We saw examples where people's dignity was not always protected when they needed assistance to the toilet. People choices about their care and their views and decisions they had made about their care were not always listened to and acted upon.

People were not involved in the planning and review of their care and relatives felt that where it was necessary for them to be part of the review of their family members care they were not actively involved. People were not supported to continue with their hobbies and interests. People reported they had no means of occupying their time. Where people had any concerns they were able to make a complaint, however the records that we saw about complaints could not evidence that these had always been responded to the complainant's satisfaction.

There was a lack of continuity in the management of the service, had meant there was not always clear and visible leadership. The culture of the service was not open and transparent, which meant serious incidents had not been discussed with the person, where relevant their family members, staff or external agencies. The poor record keeping of the incidents of abuse meant that the provider could not be assured that those harmed had received the right and proper treatment. The provider was reactive to concerns. The providers systems to check the service was delivering high quality care was inadequate in identifying areas for improvement which had resulted in people receiving poor quality care and treatment. The provider had not informed CQC of important events that occurred at the service, in line with current legislation.

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.
People were not protected from harm and abuse. Incidents of abuse had not been reported to external agencies.
Risks to people were assessed however the plans that were put in place were not robust as further incidents of harm had happened to people. The provider had not identified further potential risks to people.

Is the service effective?

Requires Improvement

The service was not always effective.
People received care that was not always in line with their best interest. The provider could not clearly demonstrate that the MCA principles had been followed, and where restrictive care practices were in place that consideration of a deprivation was required. Staff reported that their training was inconsistent. The provider did not have checks in place to be assured staff understood the training they had received to ensure best practice was being implemented. People were supported to eat a healthy balanced diet and were supported with their health care needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff were not consistently kind towards them and staff were not able to always protect people's dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People did not always receive the care and support that met their individual needs.
The provider gave people the information to be able to complain. The providers records of complaints did not always demonstrate these were responded to the complainants satisfaction.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of continuity in the management of the service, which had impacted on people, staff and the service provided.
The providers culture was not open and transparent, and where incidents of abuse had occurred people, their family and external agencies had not been contacted.
The provider had failed to notify CQC of events that had happened in the home.
The provider was reactive to concerns raised, their own checks had not identified areas of serious concern so action could be taken in a timely way.

The Shrubbery 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 checked 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.

At the last inspection on 19 January 2017 the service was rated as good. This inspection was a comprehensive inspection and took place on 10 and 11 August 2017 and was unannounced. This inspection was completed by one inspector and one expert by experience. An expert by experience is a person who has had experience was services for older people who may have dementia.

This inspection was completed due to serious concerns raised by a member of the public. We visited the service to understand if people were safe from harm and receiving good quality care. We spoke with the local authority and the Clinical Commissioning Group (CCG) about information they held about the provider prior to our inspection.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with five people and spent time with them in the communal areas of the home. Some of the people we spoke with were not able to tell us in detail about their care and support because of their complex needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 11 relatives. We spoke with six care staff, the agency staff member, the chef and the hostess, two nurses, the interim home manager, the compliance manager, the managing director and the provider. We looked at a sample of people's care and medication records. We also looked at complaints; incident and accident,

letters sent to people and relatives from the provider, three staff recruitment files and the compliance manager's audit.

Inadequate

Is the service safe?

Our findings

We received concerns from a member of the public about allegations of abuse and the provider had not taken appropriate action to ensure people were kept safe from harm. Following this information we visited the home to ensure people were safe. We found the provider had failed to keep people safe. People had been harmed or put at risk of harm and the provider had not taken sufficient steps to protect people and keep them safe.

We looked at where the provider had identified risks to people to see how they were protecting them from harm. The provider had put some plans in place to help reduce the risk of harm to people. For example, a staff member being continually visible in the communal areas of the home and frequent observations on those people identified as posing a risk of harm. However these efforts had not been enough to fully protect people as records we looked at showed further incidents causing harm to people had happened. The provider could not demonstrate that they had reviewed these further incidents and taken enough action to keep people safe and protect them from harm.

During our inspection we identified a person who remained at risk of harm of potential abuse . We discussed with the interim manager about this as we needed assurances people were going to be kept safe. The provider had not identified this person as being at potential risk, but told us they would address these identified areas of concerns and involve people and where appropriate their family members to help keep the person safe.

We gave staff a scenario of a type of abuse taking place within the home, to understand what action they would take if they witnessed this. The responses staff gave us demonstrated staff were not aware of what action was appropriate if they saw abuse had taken place. One staff member told us they would speak with the staff member who had been abusive and report it to a senior staff member if the abuse had happened again. Another staff member told us they would report to an external agency if they felt action had not been taken in the right way by senior management. However, where further incidents of abuse had happened within the home they had not done this. One staff member said, "There is a phone number on the board in the staff's room, but I don't know who that is. I clearly need safeguarding training, as I just don't know".

On the day of our inspection the staff member who worked in the communal area's to keep people safe was an agency staff member. They were not aware of people's care needs and sought constant support from permanent staff members. We spoke with the interim manager about the appropriate support people were receiving in the communal area. They told us permanent staff had raised previous concerns with them about the agency staff and their lack of understanding of people's needs. However, with this known concern, the deployment of the agency staff had not been considered when keeping people safe and protecting them from potential risk of harm.

We spoke with the interim home manager and the compliance manager about the safeguarding training staff had received. The compliance manager explained that further training was going to be given to all staff. However, we found the provider had not considered how they would check staff's competence and

understanding of how to protect people from harm. The provider did not have assurances that what staff were told was going to be put into practice.

All of the above information demonstrates there was a breach in regulation which was Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe care and treatment.

During our inspection we identified two types of abuse that people had experienced while living in the home. The provider had placed people at risk of harm and had not protected them from actual harm. The provider had not taken robust actions to adequately safeguard people from abuse and prevent abuse from happening.

Our findings showed the management staff did not demonstrate a good awareness of the safeguarding procedures and how to follow these. Where different types of abuse had taken place the provider had not put sufficient measures in place to protect people from further harm.

People were not protected from abuse. In one example we found some people who were living in the home had been abused by another person who also lived in the home. The measures that had been put in place were not adequate, as there had been eight further incidents of harm over a six week period. The provider had taken further action to by serving the person notice to leave within 28 days. The provider had not reviewed their plans during the 28 days to ensure that all that was reasonably practicable to keep people safe from further harm.

We were alerted to another incident of abuse against a person living in the home and a member of staff. The person told us, "I had a row with [staff member's name] it was about going to the toilet, [they] took me in the toilet, poked [their] finger in my face and said you don't ask to go to the toilet at lunch time. I was upset, it made me cry". They told us their family member had spoken with a nurse and, "The boss" when this happened and the staff member had apologised to them and no further incidents had happened again.

We spoke with staff about how they kept people safe from abuse. Staff told us how there had been incidents of service user to service user abuse taking place in the home. One staff member told us about this and said, "It's not safe. [The abuse] has been going on too long". They continued to say, "[The abuse] has gotten worse, we document it in [the person's] record and report to the nurse, but we've been writing about it but nothing has happened". While staff recognised different types of abuse they did not understand how to ensure people were always protected in the right way. Where incidents had happened, the provider had not recognised the seriousness of this and had not reported these concerns to external agencies for advice and support so that further action had been taken.

The provider did not have effective systems in place to promptly investigate and report where evidence had been gained incidents of abuse. We spoke with the interim manager and compliance manager about the staff member being verbally abusive. They were unaware of this and the provider's records did not show this incident had happened or what action the provider had taken as a result. While the provider confirmed to us that the staff member had been spoken they could not be assured that sufficient action was taken against the staff member in order to prevent it from happening again to other people who lived in the home. The provider told us they would review their policies around management of their staff and safeguarding procedures. The interim manager told us they would discuss this matter with the local authority.

Where the provider had identified potential abuse had taken place they had not reported this to the local authority appropriately or to the police to ensure that the right action was being taken to keep people safe from potential harm. During our inspection we spoke with the local authority to share our concerns so they

could begin their procedures.

All of the above information demonstrates there was a breach in regulation which was Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We looked at two recruitment files of new staff member who were working in the home. In one of these files we saw that the staff member had worked in previous healthcare settings, however only two personal references had been sought and not a reference from their previous employer. The provider confirmed that a professional reference was required, but did not know why it had not in this care, and agreed that a professional reference would be sought. In both of the new staff recruitment files we saw that interviews had taken place, however, the provider could not demonstrate that their interview questions had been asked as the written responses lacked detail. For example, in one interview record it stated "30 years' experience in care", however this did not demonstrate the provider was selecting potential staff which were in-line with their identified values. Therefore, the provider could not evidence the staff member they had employed had the right skills and were safe to work in the home.

All of the above evidence demonstrates a breach in Regulation 19 of the health and social care Act 2008 (regulated activities 2014) Fit and proper persons employed.

People and relatives who spoke to us about staffing levels gave a mixed response as some felt more staff were needed. One person said, "When you ring the bell you have to wait, always wait." Six relatives we spoke with felt that more staff were needed to meet people's needs, with one relative saying, "At times I think they need more staff but they do what they can".

Staff told us there had been a period of time where there were not always enough staff to support people's care needs, however this had improved over the last month. Staff told us that better deployment of staff had meant they were able to keep people safer, for example a staff member present in the communal area. We spent time in the communal areas of the home to understand how people were supported to stay safe. We saw that staff remained in the communal lounge requested by the provider to keep people safe.

People and relatives we spoke with did not raise any concerns about how their medication was managed. We spoke with a nurse about the medication they gave people and the possible side effects and they showed a good awareness of this. We found people's medication was stored and managed in a way which helped to keep people safe.

Requires Improvement

Is the service effective?

Our findings

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

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

People we spoke with told us staff sought their agreement before carrying out any personal care and staff respected their wishes and their choices. Staff we spoke with understood their day to day roles and responsibilities in regards to gaining consent for personal care and what this meant or how it affected the way the person was to be cared for. However staff spoke to us about one person where they were now nursed in bed due to previous falls. We needed to understand if the action taken by staff was in-line with the MCA principles.

We looked at the person's care records to understand how staff had reached the decision for them to be nursed in bed and whether this was in the person's best interest. We saw that a staff member had completed a mental capacity assessment. The records did not show how the staff member had reached the judgement that the person lacked capacity to make decisions about this aspect of their care. Where decisions had been made to nurse the person in bed, the records did not show that the person, or their family member had been involved in the decision making process and whether the care was the least restrictive option and in the person's best interest. The provider could not demonstrate that the principles of the MCA had been followed. The provider had not considered whether this form of control and restraint amounted to a deprivation of liberty. The person's care records showed that a DoL would need to be requested, however the provider and the person's records did not demonstrate this had been considered or actioned.

The interim manager spoke of how they involved one person's family member as they had lasting power of attorney (LPOA) for the person's health and well-being. However the provider did not have evidence to demonstrate that the family member had the legal powers. Discussions and decisions were being made about the person's care and treatment on their behalf. The interim manager confirmed that they did not hold any evidence to demonstrate were people had a power of attorney in place and told us this would be requested to update their records so that decisions being were made lawfully.

All of the above information demonstrates there was a breach in regulation which was Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Need for consent.

People we spoke with felt staff knew how to look after them in the right way. Relatives we spoke with told us that staff worked hard and had the skills needed to care for their family member. We spoke with staff about the training and support they received to ensure they could deliver care in the right way. From conversations with staff it showed the training they had received varied, for example some staff had received manual handling training, while another staff member told us they had not had training to use a stand aid hoist. The staff member told us that until they had the training they did not use that piece of equipment. Through talking with staff it was evident that further training and support was needed around safeguarding and how to respond to this.

The compliance manager explained to us they had identified a quality concern with the previous training given to staff. They said they were introducing a new training programme which was online so they could check to see if staff were completing the training when required. The clinical lead nurse told us that staff supervisions and checks were an area for improvement and said the provider had given them additional time to be able to put these in place for the staff, however these competency checks had not taken place at the time of the inspection.

Following our conversation with the provider and interim manager about this they assured us this would be reflected in future staff supervisions and through practice discussions at team meetings, so they had assurances staff understood the training they received and to have a positive impact for people.

We spoke with three people about the food, two people were positive, with one person saying, "The food is very nice, I have no complaints about it". However a further person told us, "I don't do anything during the day to build up an appetite. You get what they cook you". We spent time with people in the communal areas of the home during lunch time to understand people's experience of meal time. We saw people were offered a choice of meals from the menu and staff knew which people required further assistance with their meals and supported them to do this at a pace which suited the person. We saw people were offered hot and cold drinks throughout the day and staff ensured people had drinks to hand or supported people to drink if they needed assistance. Staff understood the importance of ensuring people who were at risk of not drinking enough fluids were supported to do so to keep them healthy.

We spoke with the staff about those people who may be at risk of losing weight. Staff told us and we saw that people were weighed monthly to ensure they maintained a healthy weight. The nurse showed us where people had been identified as losing weight and we could see that action had been taken to ensure people had enough food and fluid to keep them healthy. Where people were supported to maintain their nutrition we saw that this was managed in a safe way and as instructed by the person's doctor.

People we spoke with told us they had access to healthcare professionals when they needed and appointments with health professionals were arranged in a timely manner when they requested these. One relative told us their family member saw a chiropodist when needed and a further relative told us the staff informed them if their family member had become unwell and needed the doctor or hospital treatment.

Requires Improvement

Is the service caring?

Our findings

We looked to see how people's dignity was maintained and found occasions where staff were not always able to consistently maintain this for people. This was because staff struggled to meet people's continence needs in a timely way, which left some people in wet clothes while they waited for assistance. One person told us their trousers were wet and they were waiting for the toilet. Over the two days of our inspection we noted a strong smell of stale urine in the lounge area. We raised this with the provider, who had not noticed this smell. Following our inspection the provider sent us an action plan which stated the carpets in the lounge would be deep cleaned.

We received mixed responses from people and relatives about the support offered to them to share their views about their care. People felt their care needs were met, however all people and relatives we spoke with felt more could be done for their social and emotional well-being and stated this had been raised as an issue before. A visiting friend told us the person they visited was, "Bored out of their mind" as there was no suitable activities or stimulation for the person. While another relative told us they paid for music therapy for their family member and said, "Activities are not happening here." And a further relative told us, "I come every day [the person] is lonely. The carers don't have time to talk to them". Staff told us they often felt frustrated that they did not have time to spend with people which meant people were left with little interaction. One staff member said, "I wish we had more time with people. I used to have time". The interim home manager explained that staff were to interact with people while providing personal care. Staff told us this worked in some cases, for example, while supporting the person to wash, however staff told us that most people living in the home required regular support with their continence needs throughout the day. They told us that this meant it was not always the most appropriate time to be having conversations about their interests and hobbies.

People did not consistently experience kind and caring staff. Two people we spoke with told us staff were kind and caring towards them. However two people spoke of occasions where staff had been unkind towards them. One person told us "Yes I do think they are kind but they have their off days, you can tell by the way they speak to you and how they react". They continued to say that when they rang the call bell for assistance some staff would say, "What do you want, what do you ring for', I only ring for a drink. They complain because I ring the bell". All relative we spoke with felt staff were kind towards their family member.

We spent time in the communal areas of the home and found that staff's approach with people was kind and patient. Staff we spoke with talked about people with affection. One staff member said "[People] are looked after. I look after them as if they were my family". Where one person became anxious we saw how staff supported the person, which resulted in the person being more settled and started to smile. While staff supported people while using the hoist they reassured the people and explained what was happening. We saw that while staff were busy they took their time with people, did not rush them and went at their pace. Where relatives came to visit, we saw staff welcomed them into the home.

People we spoke with told us staff respected their privacy. People told us how staff knocked their bedroom

door and waited for a reply before they entered their room. While another person told us staff ensured the bathroom door was closed when providing personal care. People said they chose their clothes and dressed in their preferred style. We saw staff ensured people's clothes were clean and assisted people to change if needed.

Requires Improvement

Is the service responsive?

Our findings

People did not always received responsive and timely care. Two people and four relatives we spoke with told us that staff could not always meet people's continence care needs in a timely way. One person told us they had asked staff, "Several times" to go to the toilet and then told us, "I have been waiting, my trousers are wet, now my skin is itching". While one relative told us, "The staff look pushed, people have to wait for the toilet". Another relative told us, "I am here twice a day and see people waiting for the toilet". We spent time in the communal areas of the home and saw staff were busy supporting people with their requests. When one person asked the agency staff member if they could assist them to the toilet, however the agency staff was not able to support them as they were not aware of the person's continence needs. The person had to wait until two staff members became available to support them.

People told us they were not always involved in the development and review of their care. Relatives told us that where it was necessary to speak with staff about their family member's care this did not always happen. One relative told us how they had not spoken with staff about the care and only spoken with staff in passing. While a further relative said, "No, I have never had a review of [the person's] care". One relative told us, "[Person's name] wasn't having a regular shower and is incontinent so needs it". They told us they spoke with a staff member and their family member now had a shower once a week. We spoke with staff about whether they had time to bath and shower people when the person wished. Staff told us they had enough time to give people a shower now that all of these showers had been fixed by the provider. Three staff members told us they had a rota for baths, which they used as a guide to ensure each person had a shower at least once a week, however staff felt they were able to offer more frequent showers if the person requested this.

The clinical lead nurse told us they had identified that better communication between people, their relatives and staff had been an area identified for improvement. They told us that following a team meeting with the provider each person living in the home had been allocated a named nurse and it would be the nurses responsibility to co-ordinate the reviews of people's care. They told us that while the nurses had been assigned to people, the reviews of people's care had not begun yet.

We asked people if they were supported to maintain their hobbies and interests. Some people we spoke with told us that they did not wish to pursue their hobbies and interests as they wanted a more relaxed pace of life. We spoke with some people who wished to remain in the bedrooms and told us staff respected their wishes. However, other people we spoke with told us there was not much happening in the home. One person told us, "I would like to see us doing more. There is nothing to do I just sit in my room. I like music, I have a radio, they put it on if I ask". They continued to say, "Some of the residents are capable of doing things if they were given the chance". We saw this person did not have anything in their room as way of entertainment, their radio was out of reach and there were no books or magazines for them to read. One visitor told us the person they had visited was "Bored" as they did not have items that were tailored to their care needs to enable them to read books, which they enjoyed doing. A further relative told us, "[The person] really missed going to church [they] used to go most days. No-one seemed to be able to find anyone to give [them] communion". They continued to say, "Then a new activity worker came he got someone here pretty

quick, but he left and no-one has come from church again." The provider told us they were actively recruiting for an activities co-ordinator but had not filled this position yet.

All of the above evidence demonstrates a breach in Regulation 9 of the health and social care Act 2008 (regulated activities 2014) person centred care.

We looked at two people's care plan to understand if staff were responding to changes in people's health. The records showed staff monitored their health care needs, where there had been changes in people's health this had been reviewed by the staff and further guidance sought. In one care record we saw evidence staff had sought input from the person's doctor and staff had followed this guidance to ensure the person was receiving the correct care and support.

Staff told us they worked together and communication on all levels was improving. Care staff told us they had better communication with the nurses, and the nurse we spoke with told us this culture was improving to ensure they all worked together as a team. All staff we spoke with and we saw that they had detailed handover of information of people's care needs. Staff felt that due to the good levels of communication that were in place, team meetings and on-going communication, people received responsive care in a timely way.

The provider shared information with people about how to raise a complaint about the service provision. This information gave people who used the service details about expectations around how and when the complaint would be responded to, along with details for external agencies were they not satisfied with the outcome. People and relatives told us there had been some manager changes and some were unclear about who the current manager was. However, relatives told us the provider had been visiting the home daily and having meetings with them and their family members to understand any concerns. We saw that where relatives and people had raised concerns at a meeting about improvements to the environment the provider had responded to these with fortnightly updates about the progress.

We looked at the provider's complaints over the last eight months and saw that the provider had received two complaints. The record for one complaint showed this had been investigated in-line with the provider's policy and procedures and where possible a resolution was found. However there were no records for the second complaint to demonstrate that the provider had followed their own policy and procedure. We did find that information had been recorded on the staff information sheet about people as an area to address when supporting the person which was in-line with the complaint. We discussed with the provider that better record keeping of complaints received and how they are responded was needed to demonstrate these were acted upon and that lessons had been learnt to improve future practice.

Inadequate

Is the service well-led?

Our findings

The registered manager had resigned from their post in June 2017 and were going through the process to de-register with us. 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.

Since the registered managers resignation in June 2017 there had been two further interim managers in post. On the first day of our inspection the compliance manager told us they had interviewed two potential home managers and felt positive that the position for the registered manager would be filled.

From what we had saw, heard and read over the two days we found that the provider's culture was not open or transparent. We found the provider had failed to inform people, relatives, and external agencies about repeated potential abuse that had taken place in the home. The provider had failed to recognise the seriousness of these incidents and in doing so had neglected their duty to provide safe care to those who lived at their service. The culture that had developed within the service and inaction by senior management had placed people at unnecessary harm as there were inadequate procedures in place to protect people.

Incidents of one type of abuse had been written by staff in one record. This written record did not give sufficient detail to always determine which specific person had been potentially harmed and what the impact was to the person. The poor record keeping, meant the provider did not have the right evidence to ensure those people who had experienced potential harm had received the right care and treatment. The incidents that we read amounted to potential assault. The incidents alerted us to the need to involve other agencies, such as the police to investigate the concerns. We asked the provider to notify the relevant authorities as the provider had failed to notify external agencies of these incidents. Due to the provider's records not being clear or complete this had a significant impact on the people affected by the abuse as the provider could not be assured that the relevant authorities now handling the investigation could take the right and sufficient action against the abuser.

The provider had failed to be proactive in their approach and had not identified through their own quality monitoring systems failings in their support provided for people living at the home. The provider had not acted on identified areas for improvement in a timely way, such as working with people and relatives to involve and include them in their care and improvements to the environment. We spoke with the compliance manager who showed us an action plan they had made in December 2016 which had identified some area's for improvement and told us that some areas had been actioned, but it had been slow progress. They continued to tell us that since the registered manager had left in June 2017 there had been two different interim managers, and some of the areas of identified concerns, such as people's involvement remained as an action to complete. The compliance manager could not give a date of when these areas would be improved to ensure people were receiving high quality care in a timely way.

We spoke with people and relatives about the way the service was run. People we spoke with did not directly

discuss this with us, however relatives did comment. One relative said, "We are unsure who people are, there are a lot of uniforms. It's not easy to see who is in charge". Another relative said, "There is no manager here at the moment, so I spoke to the owner and the nurse". While a further relative told us they had not been asked about their views of the way the service had been run. Staff told us that the change in managers had been unsettling; however felt the interim manager was approachable.

Relatives and staff told us the provider had been visiting the home daily over the last month and spoke with people and relatives about concerns they have. However, we found the provider was only reacting to concerns raised by people, relatives and staff. While we could see that the provider was now listening and making improvements to the environment of the home there had been a delay in their response their own systems had not identified the improvements that were needed. For example, staff reported that the provider had now fixed the showers. When we asked staff how long the showers had been broken, one staff member said, "Oh, months". A further staff member told us that the bath had not worked, "For several months", but were aware this was going to also be replaced. The provider confirmed that a new bath had been ordered. Staff also reported that equipment to ensure people could receive the right care and support had now been supplied by the provider, for example a stand aid in order to move two people who lived in the home safely. The compliance manager reported to us that the mattresses that had been identified as needing replacing in December 2016 had now been ordered and 21 new mattresses were being delivered.

The interim home manager who was in place since the 17 July 2017 told us they were, "Not ready to be a manager"; they told us they lacked the knowledge to be able to do the role effectively and in the right way. They told us the compliance manager had supported them, and they, "Would not have been able to cope without them". On our second day of inspection one of the provider's came to support the interim manager. The interim manager expressed their concern about their knowledge to take the right action for our raised concerns and looked to us for advice and support. The provider had not consistently identify when the interim manager required support to manage the home. We had to re-enforce to the provider that the interim manager had expressed their concern about their abilities to respond to the concerns we had raised and they may want to reconsider leaving the interim manager alone during a time where we had raised serious concerns. The provider confirmed they would stay to support the interim manager.

All of the above evidence demonstrates a breach in Regulation 17 of the health and social care Act 2008 (regulated activities 2014) Good Governance.

Following our inspection the provider wrote to us to advise us of actions they were putting in place to address the serious concerns we had raised. The provider had recognised in their action plan that these concerns required addressing promptly. However, while we understand the provider was putting some actions into place, these were only as a result of our inspection. Given our concerns identified and the provider's culture for identifying, responding and actioning concerns, we do not have the assurance that the provider would have taken serious and robust action without our input.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always have their individual needs met as the provider did not always give people the opportunity to discuss their care and treatment.

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 The provider had not always ensured they had followed the Mental Capacity Act principles to ensure they were providing care in the right way. Act.

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 The provider had not always ensured care was being delivered in a safe way. Where risks to people had been identified, the provider had not always done all that was reasonably practicable to reduce the risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust systems in place to ensure the staff who they employed had the right skills, qualifications and

experience.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse or potential abuse. Systems that were in place were not always adequate to protect people. The provider did not have an established system to effectively investigate and report incidents they had become aware of.

The enforcement action we took:

Imposed a condition for the provider to submit a monthly report.

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 The provider did not have robust systems in place to assess and monitor the service to ensure it delivered high quality safe care to the people who lived in the home. The provider did not drive improvement, recognise and promptly address this in a timely way. The providers records were not accurate or complete.

The enforcement action we took:

Impose a condition to submit a monthly report.