Astracare (UK) Limited

Harvey Centre - Mental Health Nursing Home

Inspection report

19-23 The Street
Weeley
Clacton On Sea
Essex
CO16 9JF

Tel: 01255831457

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Harvey Centre is an 18 bedded nursing home for people living with mental health illnesses. There were 14 people in the service when we inspected on 2 and 6 November 2017. We carried out this unannounced, comprehensive inspection to check that the provider had made the improvements required following our inspection on 16 and 21 February 2017.

During our inspection in February 2017 we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was placed into Special Measures and we told the provider to take action to address and improve medicine management, infection control practices, risk management, care records and governance and management systems. We received an action plan from the provider and we have kept the service under review, with the expectation that significant improvement is to have been made within a six month timeframe.

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

At this inspection we again found widespread and significant shortfalls in the way the service was managed and regulations continued to not be met. Despite our previous concerns the provider continued to fail to ensure that there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively.

There was not an effective system in place to ensure there were sufficient numbers of staff on duty to support people and meet their needs. There were not enough staff to provide adequate supervision, stimulation and meaningful activity. This had a direct impact on people's safety and welfare.

People's care had not been co-ordinated or managed to ensure their specific needs were being met. Risks to people injuring themselves or others were not appropriately managed. There was a lack of oversight to identify and manage risks associated with infection control, environment and equipment. Improvements were seen in the management of people's medicines but care records gave conflicting information regarding the support people required with these.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way. They did not always respond appropriately and in a timely manner to all of people's needs.

Care documents remained inconsistent and did not demonstrate a planned approach to support people.

There was a lack of clear guidance and key information for staff to enable them to support people with their emotional and mental health related needs. There was a lack of understanding and appropriate resources to support people with physical or mental stimulation appropriate for people living with dementia or other mental health conditions.

Additional training had been provided to staff but the provider had failed to ensure this learning was being put into practice. Staff were aware of their responsibilities with regard to safeguarding people from abuse. However, they did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

Staff demonstrated an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) but the principles of the MCA were not always followed by staff. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

The provider had failed to promote a positive culture within the service and there was an institutional approach to the delivery of care and support. Quality assurance systems had failed to identify the issues we found during our inspection.

Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements following our previous inspections in February 2017 and May 2016. This resulted in continued non-compliance with regulations and poor outcomes for people.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection we took immediate enforcement action to restrict admissions and force improvement. We were also made aware of an ongoing police investigation in connection with the Harvey Centre and will continue to liaise with the police and local safeguarding authority. The Commission is further considering its enforcement powers. This includes taking action in line with our enforcement procedures to begin the process of cancelling the provider's registration.

On 10 November 2017 the provider advised us that they would not be challenging the Commission's urgent action. They also advised a decision had been made to close the service by 12 December 2017.

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.

There were insufficient numbers of staff on duty to meet people's care and support needs.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely.

Risks associated with infection control, environment and equipment were not being identified or managed effectively.

Is the service effective?

Inadequate

The service was not effective.

Learning from training and development was not always put into practice.

People were not always supported effectively with their nutritional needs.

People were not always supported in line with the Mental Capacity Act.

Is the service caring?

Inadequate

The service was not caring.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

Although some staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way.

Is the service responsive?

Inadequate

The service was not responsive.

Care documents were inconsistent and did not demonstrate a planned approach to support people.

There was a lack of general activity throughout the day to ensure people's well-being.

It was unclear how the results of people's feedback was used to drive forward improvements.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to promote a positive culture within the service and there was an institutional approach to the delivery of care and support.

Quality assurance systems had failed to identify the issues we found during our inspection.

Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements.

Harvey Centre - Mental Health 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 unannounced inspection took place on 2 and 6 November 2017. The inspection on 6 November commenced at 8pm to give us an understanding of staffing and how people's needs were being met during the evening and night. The inspection team was made up of two inspectors and a pharmacy specialist.

Before the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with five people living at the service and one relative. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the registered manager, the assistant director, six other members of staff and an agency worker.

To help us assess how people's care and support needs were being met we reviewed nine people's care records and other information, for example their risk assessments and medicines records.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2016 we found that the inappropriate management of people's medicines placed them at risk of harm. People were also not protected from risks relating to their care and support needs or risks associated with the unsafe management of food and ineffective cleaning regimes. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. At this inspection we found improvements had been made in relation to medicines management but sufficient improvements had not been made in other areas which meant people continued to be at risk of harm. In addition, further breaches of regulation were found.

People's care was still not co-ordinated or managed to ensure their specific needs were being met safely. Individual risk assessments were not effective and effective care planning strategies were not in place in relation to people's mental health and dementia related needs, nutritional needs, skin integrity and prevention of pressure ulcers. Staff did not have sufficient guidance on the support people required to meet these needs and keep them consistently safe.

One person was observed to be choking on their drink on the first day of inspection. The member of staff supporting the person commented to the nurse on duty "[Person] keeps choking on his drink lately." The nurse in charge responded that they thought the person had had a Speech and Language Therapist team (SALT) assessment but this was not checked and the member of staff continued to give the person their drink. This information was shared with the registered manager and assistant director on 2 November 2017 so they could take action.

On the second day of inspection we checked the persons care records. There was no information logged recording them choking on their fluids on 2 November 2017. We again observed the person being assisted with a drink and saw that they coughed and sputtered on the first mouthful.
A choking risk assessment for the person pointed to an assessment completed by SALT in July 2017. At this time, a pureed diet was advised but no changes to fluids. A risk assessment completed on the 28 September 2017 highlighted that the person had difficulty swallowing and was at risk of choking on food and at risk of aspiration. There had been no new referral to the SALT team in light of the new concerns. The risk assessment also stated that staff should be made aware of foods to avoid. No list of what foods the person should avoid was available to staff who were serving their meal. Staff lacked understanding and knowledge on the risk of choking and aspiration and because of the lack of robust care planning and risk assessment the person was at risk of serious avoidable harm.

At our last two inspections we found that people were not adequately protected against the risk of acquiring a pressure ulcer. This continued to be the case. One person with two pressure ulcers had been assessed as being at high risk of further pressure ulcers. There was no body map in the person's care records to show the position of the ulcers they already had. The nurse in charge informed us the person also had a number of skin tears but there were insufficient details in the care plan to inform staff how to manage and mitigate this risk. Control measures in place to reduce the risk of pressure ulcers included two hourly repositioning day and night. Records seen for the nightshift of the 1, 2 and 5 November 2017 showed that no repositioning had

been recorded throughout the night. This meant on these dates staff could not demonstrate that action to prevent further skin breakdown had been taken for over 10 hours. We asked the nurse in charge how often the person needed to be repositioned, they replied, "I think its four hourly." The carer on duty corrected the nurse and said its two hourly. We asked the nurse if this happened. They replied "It depends how busy we are." The lack of night staff knowledge of pressure care for this person and the inadequate care plan for prevention and intervention placed them at significant risk of further skin breakdown, pain and infection which could lead to poor health outcomes, discomfort and poor quality of life.

A number of people living in the service often became anxious and agitated. At times this would also lead to verbal and physical aggression. The care plans for seven people informed staff that there was a risk the person could become unsettled during personal care which would potentially put the person and staff in a vulnerable position and at risk of injury. However there was no information for staff on how the risks could be reduced for each individual as far as possible. Generic interventions were given regarding staff 'observing for early warning signs,' however there were no details of what these signs might be. Without this information staff may not recognise when a person's emotions were becoming heightened enabling them to take positive action to prevent a high risk situation occurring. This could mean distress and harm for the person involved as well as putting others and staff at risk of physical or verbal abuse.

People continued to be unprotected against the risks associated with poor infection control and food hygiene. The small kitchen area adjacent to the lounge used to prepare drinks, snacks and store leftover food was unlocked and accessible to people. The kitchen was unclean, including dirty floor, fridge, cupboards, sink and dishcloths. The kitchen cleaning schedule was only marked to show that the kitchen had been cleaned on four days during the month of October 2017. The temperature of the fridge had not been taken and there was no fridge thermometer available to do so. It was not possible for staff to demonstrate that the fridge was keeping food at the right temperature to avoid deterioration of food quality and risk of bacteria/infection. An undated, uncovered dessert was stored in the fridge along with undated, dirty bottles of mayonnaise and ketchup. Uncovered and undated drinks were also stored. People living at the service due to their frailty are more susceptible to risks of the spread of infection including risks around cleanliness and food poisoning. There had been no monitoring of the cleaning of the kitchen despite this being an area of concern found at our last inspection.

There continued to be a general lack of oversight to identify and manage risks associated with infection control, environment and equipment. The assistant director told us that plastic sheets used to cover people's beds were wiped down with antibacterial spray but they could not show us when this occurred or how staff knew whether or not this task had been completed. Commodes frames were dirty, as were communal wheelchairs. A wheelchair was also seen with torn padding on the arms meaning it was unable to be cleaned effectively. Used protective gloves were left on the side of a person's chest of drawers. We also observed staff placing used protective gloves in the bin in the office rather than disposing of them in the place where they had been used in appropriate bins for infection control. These poor practices placed people at risk of harm due to spread of infection which could be seriously detrimental to their health.

A lack of emergency planning meant people were at risk of exposure to harm in an emergency situation such as a fire or in the event of an illness or injury which requires hospital admission. We asked the nurse in charge of the late shift, the nurse in charge of the day shift and a carer to show us people's Personal Emergency Evacuation Plans (PEEPS). None of them were able to provide these and told us they thought they were kept in the main office which was locked. The next day the registered manager told us that these were available in the nurses office but the nurses in charge of both shifts were unaware of this. They would therefore be unable to quickly locate these in the event of an emergency should an evacuation be necessary.

In addition important information for people who may require emergency care was not readily available to night staff. There was no photocopier available to be able to copy people's medicines records to send with emergency services to inform hospital staff. The nurse in charge told us that people's medicines were recorded on service user's hospital transfer sheets but we saw this information was missing, incomplete or out of date.

Records of incidents and accidents did not demonstrate what action had been taken to ensure people's health and well-being following an incident. Although incidents had been logged there was no evidence that the information had been analysed to identify trends and themes in order to reduce future risks. This also meant opportunities had been lost to learn from incidents in order to improve the care and support provided.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified shortfalls in staffing numbers and their deployment which had a direct impact on people's safety and the care and support being provided.

The system in place for determining staffing levels was not effective to ensure sufficient numbers of staff to meet people's needs. Dependency tools provided an overall total score to calculate staffing levels and did not take into account people identified as needing the assistance of three care staff or that another two people required one-to-one supervision throughout the day. Additional tasks allocated to staff such as responsibilities for food handling had also not been considered when calculating number of staff required. Neither had time been factored in to allow staff to spend quality time engaging service users in meaningful activities. This did not support staff to effectively provide the right care and reduce risks associated with peoples escalating anxieties.

Rotas showed that between the hours of 7am and 9pm there was one nurse and four care staff rostered to work each day. Two people required one to one supervision throughout the day. One carer had the designated role of food handler each day which also involved clearing and washing up after lunch in the kitchen away from the main part of the building. Immediately after lunch the nurse was administering medicines which left one member of staff to provide support to the remaining 12 people, during this time. A member of staff told us, "There used to be enough staff but now there isn't. I don't want to say more because I will get in trouble. They really struggle on the ward."

The registered manager told us that six people needed the assistance of at least two care staff to get to bed. Three of these usually went to bed after 9pm. The registered manager and other staff told us that at times all three of these people required the assistance of three staff, particularly during moving and handling and provision of their personal care due to their high levels of anxiety and agitation. Despite this there were only two members of staff on duty each night after 9pm.

The night staff continued to assist service users to bed until 11pm. Between 9pm and 11pm no checks were made on those already in bed. The nurse in charge told us, "It's ok. I know where they all are." However they failed to recognise that should someone be in distress or needing assistance they would be unaware since checks had not been carried out. This meant care was not being provided in line with their assessed needs.

A member of staff told us that most nights they would be in one person's room throughout the night because they were so unsettled. Another person wandered day and night and required hourly checks. Their care plan guided staff, ' If [person] continues to be restless they should be brought to the communal

area and should be monitored on a 1-1 basis.' It is unclear how this would be possible if other people required assistance during the night. A member of staff told us, "There are two people who should be on 1-1 past nine but they are not. It affects everyone else as well." This demonstrated that people could not be assured that there would be enough staff available to meet their needs during the night.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of their responsibilities with regard to safeguarding people from abuse and told us they felt comfortable reporting concerns to the management team. However, staff did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Some improvement in medicines management was seen at this inspection such as protocols for people prescribed 'as and when required' (PRN) medication. Protocols contained information to support staff to administer PRN medicines as the prescriber intended. For individuals who experienced high levels of anxiety they included positive interventions and strategies to be used to support them in the first instance. However this was not being followed in practice. Staff were administering PRN medicines to control people's behaviour at night time because there were insufficient numbers of staff at night to provide people with safe and appropriate person centred care and support.

No one was currently receiving medicines covertly but the wording in three people's care records suggested that their medicines could be administered in this way. Appropriate approval would first need to be sought from a pharmacist to ensure that the medicines were suitable to be given in a format which could be given covertly, such as mixed with food. Without clear guidance staff may administer medicines in a way which makes them unsafe or ineffective. The person's capacity to consent and appropriate best interest decisions with relevant professionals and those advocating for the service users would also first need to take place before medicines were given covertly.

Inadequate

Is the service effective?

Our findings

Despite our feedback following our last two inspections regarding lack of choice at mealtimes this continued to be an issue. People chose their main lunchtime meal the day before but not everyone was able to remember what they had ordered. People were not asked again before their meal was served to check if this was still what they would like to eat. A member of kitchen staff serving the food asked a carer rather than the person whether they would like more custard with their dessert and took the bowl to pour on more custard without waiting for a response. Drinks were also served to people without them being asked their preference. We observed that lunchtime was chaotic as care staff struggled to meet the needs of people requiring assistance. One member of staff was called away to assist with a person who had become very agitated which left only one member of care staff in the dining area. Kitchen staff had to ask the member of care staff to intervene when one person needing support to walk attempted to get out of their chair. This meant they had to leave the person they had been assisting to eat. During the lunchtime period we observed an agency member of staff assist a person with their meal with very limited interaction or attempt at engagement.

Staff did not always check the temperature of hot drinks when given to people who were confused. We observed that one person took a sip of their drink and stated, "It's so hot." A nurse told another very confused person that their tea was too hot to drink, but still placed it in front of them. These people were at risk of picking up the hot drinks and spilling it on themselves placing them at risk of scalding and serious injury.

The risk of people becoming dehydrated was not sufficiently monitored. Nursing staff had documented that one person was reluctant to drink fluids. Their care plan stated they should have between 1500mls and two litres of fluids every day. However, it did not state how staff should monitor this and there was no fluid monitoring chart in place. In addition staff did not know what the potential risk to the person was or why their fluid intake needed monitoring. For those who did have fluid charts, there were no targets, recording of total fluid intake or monitoring of records. It was unclear how nursing staff would be alerted if people's fluid intake was insufficient and increasing their risk of dehydration, urinary tract infections and confusion.

Care plans had not been updated to reflect people's current nutritional needs. One person's care plan showed that they had choked on food in February 2017 and a referral had been made to the SALT team. The care plan recorded that there had been no further incidents of choking or dysphasia however there was no record of a SALT assessment or outcome. It was therefore unclear if a referral or assessment had been carried out and staff did not have relevant and current information with regards to the level of support the person required to reduce the risk of them choking.

This is a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider could not demonstrate people were receiving effective care and support from staff who had the knowledge, skills and competency to carry out their roles and responsibilities. At this

inspection we saw that additional training had been provided in relation to supporting people living with dementia and supporting people when they became distressed and agitated. A member of staff told us about the Therapeutic & Safe Interventions (TASI) training they had taken part in and told us they felt this gave them a greater understanding how to support people. However, staff had not been supported to use this additional training to monitor occasions when techniques learnt needed to be used. Behaviour charts did not show sufficient detail to show what had triggered a person to become anxious or agitated or demonstrate what staff had done to positively intervene and promote more positive behaviour. This meant that opportunities to learn more about what worked well for individuals had been missed. The provider had failed to monitor whether the training provided was being effective in improving people's quality of care.

Although some staff had now received training in dementia care they were not provided with the time or resources they needed to provide a holistic approach to care whereby all aspects of people's physical, emotional and psychological needs were met. There continued to be a lack of resources available to aid reminiscence or sensory stimulation to enable staff to meet people's needs more effectively.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions

Staff demonstrated an awareness of the mental capacity act. Mental capacity assessments had been completed in relation to DoLS and were also in place where people lacked capacity to make other decisions, such as about their daily routines.

However, we observed that the principles of the MCA were not always followed by staff. They did not always seek people's consent before providing support or care or act in accordance with their wishes. For example, we observed two members of staff assisting a person from the lounge at 8.15pm to help them to bed. The person had been watching television and was not asked if they would like to go to bed but told by staff that this was going to happen. This demonstrated that people were not always supported to have maximum choice and control of their lives and were not being supported in the least restrictive way possible.

People had access to health care services and received ongoing health care support where required. However they could not be assured that the guidance given by health care professionals would be followed to ensure they received safe and effective care and support in line with their current healthcare needs.

Inadequate

Is the service caring?

Our findings

The provider had not ensured the service promoted a caring and respectful culture. Although people said staff were caring and kind, staff had not been equipped with the appropriate knowledge to help them to understand the needs of people. Care staff were not supporting people in a consistent and planned way. This, therefore, placed people at risk of receiving inappropriate and poor care.

We observed that one person complained of stiffness and pain in their knees. They were distressed and had hit out at staff earlier in the day. Although the person was receiving three doses of paracetamol a day for pain relief there was no additional medicine prescribed for breakthrough pain. Their care plan said, 'If [person] is suffering from pain in hips and knees, pain relief should be reviewed and referral made.' A referral had not been made for their medicines to be reviewed and when questioned the nurse in charge failed to recognise that this was something they should be handing over to the day staff. This put the person at risk of continued pain and discomfort which could have been avoided or explored further to find out if it was contributing to their anxiety levels.

Some agency staff did not engage effectively with people. We observed an agency worker standing watching the television in the lounge rather than taking the opportunity to spend time engaging with people. People's communication skills were impaired because of their memory difficulties, physical and mental health conditions. We observed a handover and saw that agency staff were not fully informed about the communication difficulties people may have and how to work around these. The consequence of this was that agency staff had not been informed of the best way to engage with people in order to promote dignity, respect and well-being.

Although permanent staff were observed to be intuitively caring, their daily routines did not promote a culture which supported people with all of their physical, psychological and emotional needs. We observed that staff continuously swopped what they were doing to manage the risks presented and this was chaotic. For example, staff had to move between stopping people at risk of falls trying to get out of their chairs, stopping people from becoming agitated with others and oone occasion helping other staff in a complex moving and handling procedure with a person. This meant there was limited opportunity for meaningful activity to promote peoples well-being.

People's support was not led by the needs and preferences of the individual. In the last hour of the late shift staff rushed to get service users to bed prior to the start of the night shift where only two staff would be present. Between 8pm and 9pm we observed staff assisting people from the lounge to their bedrooms. Staff said to one person, "It's that time of night" and hoisted them into a wheelchair. The person was taken to their bedroom by two staff who returned to the lounge seven minutes later. The total time to assist another person from the lounge, provide personal care, assist into bed and administer a prescribed injection was nine minutes. Rushing people with their personal care and night time routine not only shows a lack of care, dignity and respect but also places them at risk of receiving care which is unsafe as appropriate time may not be given to ensure procedures are carried out correctly and in line with best practice.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service responsive?

Inadequate

Is the service responsive?

Our findings

At our last two inspections we found that the service was not always responsive to people's needs. Care plans lacked detail and had not been consistently updated to reflect people's current care needs. At this inspection we found that although the management team had spent time revising the care documents they remained inconsistent and did not demonstrate a planned approach to support people.

Care records did not demonstrate that peoples identified preferences were being followed. For example, one person was highlighted as preferring a shower to a bath, however records showed that they had been given a bath, where they had become distressed and agitated, hitting out at staff. The registered manager told us that the person was no longer able to have a shower as they could no longer stand for long enough, but this had not been reflected in the care plan or updated in anyway. There was no information about how staff could support this person effectively during personal care and no alternatives such as the use of a shower chair had been considered.

There was a lack of clear guidance and key information for staff to enable them to support people with their emotional and mental health related needs. Care plans for a number of people informed staff that people became agitated when receiving personal care. However, they contained no meaningful person centred information about how staff should support people during these times. The plans placed an emphasis on the persons behaviour being challenging and did not demonstrate an awareness of certain behaviours being a form of communication and expression of distress and anxiety.

Records were not completed thoroughly after incidents, and were not monitored by senior staff to check for staff responses and identify triggers to distressed behaviour. Entries highlighted that staff lacked understanding about how to manage high risk situations when people became anxious or distressed. For example entries included, 'Staff told the person their behaviour was inappropriate.' The impact for the service user's mental and physical health had not been considered. Staff had not recorded what action they had taken to alleviate the person's distress and whether or not this had been successful. The opportunity was missed for staff to learn from possible positive interventions which could be used subsequently in similar situations to avoid distress and risk of harm.

Care records for one person showed that staff should be analysing records of unsettled, anxious and agitated behaviour every three months. Only four behaviour charts had been completed for the previous month despite daily records showing that this person often became very agitated and at times physically aggressive. Staff told us that this person was now needing one to one support throughout the day and we observed on both days of our inspection that the person was unsettled. A three month review period to analyse the person's behaviour could mean they were experiencing distressing situations without review or consideration of changes in their support needs.

At our last two inspections we found that staff lacked understanding and appropriate resources to support people with physical or mental stimulation appropriate for people living with dementia or other mental health conditions. The majority of activity took place in a designated area for therapeutic activities which

was referred to as the 'Day Centre' and there had been limited opportunity for general activity and mental stimulation for much of the day.

We found at this inspection that staff made attempts to involve people in activity but lacked understanding about how to make this meaningful. For example, we observed a member of staff talking with a person about an article in the newspaper regarding the local hospital. They read out the headline but made no attempt to explain what it meant when the person looked confused and quickly moved on to the next topic.

The layout of the building and staff routines did not help to ensure people were able to do the things they wanted to do. The lounge area had been resituated and was now in a part of the service which people walked through constantly all day meaning those watching the television were continually interrupted. A person sitting in the conservatory was tapping the theme tune to the soap opera which was about to start on the television in the lounge. A member of staff asked if they would like to watch it and the person replied that they would. The member of staff said they would return to assist the person into the lounge area but failed to do so for another hour and a half by which time the programme had ended. We asked another person who was in the lounge watching the soap opera whether they liked the programme. They replied, "No it's too sad, I like more action." Neither of these people were therefore given the opportunity to watch the television programmes of their choosing.

There was still a focus on the day centre being used to provide for people's social needs. One person told us they had done, "Not a lot" that day and only visited the day centre twice a week. A few people at a time used the day centre together with a member of staff employed to engage people in activity. However, we did not find the activities truly developed or were reflective of individual needs and preferences. For example, on the first day of inspection three people were in the day centre. One person was sitting with a newspaper on their lap, but not reading it, another was sitting next to a member of staff but not involved in any meaningful activity and the third had a pile of bricks in front of them which the member of staff asked them to build a house with which they were unable to do. This meant a missed opportunity to promote independence and well-being.

People's care records did not accurately portray people's needs and preferences in relation to their social needs. One person's care plan stated, 'Prompt engagement with activities on the ward and in day centre. [Person] to participate in quizzes, colouring, singing, knitting and listening to music. However an additional care plan reviewed six monthly indicated the person had a lack of capacity to choose activity and due to their mental health needs would be better to engage in one to one activities with staff. This information was conflicting and further demonstrated that staff were not being provided with consistent and up to date information in order to tailor social and emotional stimulation to people's individual needs.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records demonstrated that staff did not always react appropriately to people's concerns. For example one person had told staff they were frightened of an agency worker and they thought the worker was trying to harm them. Staff did not document how they had supported, and offered reassurance to the person, or investigate the concern raised.

The provider had a complaints policy and procedure in place which was displayed. However, it was unclear how concerns had been responded to, what action had been taken and how feedback received had been used to put things right and make improvements to people's well-being and the service provided.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2017 we found that despite assurances and an action plan stating that improvements would be made following our inspection in May 2016, the provider had failed to establish effective systems and processes to assess, monitor and improve the quality and safety of the service, to ensure people received safe and effective care.

At this inspection we again found widespread and significant shortfalls in the way the service was managed and regulations continued to not be met. Despite our previous concerns the provider continued to fail to ensure that there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively.

The provider had submitted monthly progress reports and action plans in response to the conditions placed on their registration following our last inspection. These indicated that the management team were of the opinion that sufficient improvements had been made at the service and they were ready for us to re-inspect.

However, the quality assurance systems in place had failed to identify the issues we found during our inspection, including shortfalls relating to staffing levels, risk assessment, infection control, inconsistencies in care records and the absence of information to be able to support people with all of their physical and psychological needs. There was a failure to recognise and identify significant failings impacting on the quality of service provision. The provider had continued to miss opportunities to protect people from the risk of receiving inconsistent, inappropriate or unsafe care.

The provider had failed to promote a positive culture within the service and there was an institutional approach to the delivery of care and support. This was further demonstrated in the way care records and staff referred to people as, 'patients' and the main areas of the service as the, 'ward'. Harvey Centre is a residential home rather than a hospital but there had been no attempt by the management team to provide a homely environment rather than a clinical one. This approach is limiting to peoples sense of well-being and does not demonstrate an inclusive and empowering culture where people are supported according to their specific and individual needs.

Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements following our previous inspections in February 2017 and May 2016. This resulted in continued non-compliance with regulations and poor outcomes for people.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

We immediately informed the provider of the seriousness of our concerns and placed additional conditions on their registration requiring them to take urgent action to address our concerns as we believed people were or may be exposed to the risk of harm if we did not do so.

We also restricted admissions to the service to ensure that no new people would be exposed to the same risk of harm and to give the provider opportunity to focus on mitigating against the identified risks of harm that exist for those already in their care.

We continued to closely monitor the service in conjunction with commissioning bodies and local authority quality improvement and safeguarding teams. On 10 November 2017 the provider advised us that they would not be challenging the Commission's urgent action. They also advised a decision had been made to close the service by 12 December 2017.

Further information was provided to explain they spoke with people using the service, their friends and relatives. In addition they worked with local commissioners and advocates to support people to move to alternative homes. Professionals commented about how positively staff had completed this work despite the difficult circumstances.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care documents were inconsistent and did not demonstrate a planned approach to support people.

The enforcement action we took:

We imposed conditions on the providers registration that required them to take further action where we consider that specific improvement was necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We also restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

The enforcement action we took:

We imposed conditions on the providers registration that required them to take further action where we consider that specific improvement was necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We also restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care had not been co-ordinated or managed to ensure their specific needs were being met safely. Risks associated with infection control, environment and equipment were not being identified or managed effectively.

The enforcement action we took:

We imposed conditions on the providers registration that required them to take further action where we consider that specific improvement was necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We also restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

The enforcement action we took:

We imposed conditions on the providers registration that required them to take further action where we consider that specific improvement was necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We also restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always supported effectively with their nutritional needs.

The enforcement action we took:

We imposed conditions on the providers registration that required them to take further action where we consider that specific improvement was necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We also restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had failed to identify the issues we found during our inspection. Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements.

The enforcement action we took:

We imposed conditions on the providers registration that required them to take further action where we consider that specific improvement was necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We also restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff on duty to meet people's care and support needs.

The enforcement action we took:

We imposed conditions on the providers registration that required them to take further action where we consider that specific improvement was necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We also restricted admissions to the service.