Hadrian Healthcare (Hull) Limited

Berkeley House

Inspection report

Berkeley House
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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?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was unannounced and took place on 11 and 12 December 2014. The previous inspection of the service took place on 28 January 2014; the service was compliant with the regulations that were inspected at that time.

Berkeley House is registered to provide care and accommodation for a maximum of 94 people. This number includes 84 older people who may be living with dementia and 10 people who have a learning disability.

Accommodation is provided separately for people who have a learning disability in small family type bungalows adjacent to the main home. 83 people were living in the home at the time of the inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Improvements were required in how people's care and treatment was planned and delivered. Some people who lived at the service had needs that were not planned for. This led to them not receiving the care they required to keep them and other people who lived at the service safe.

Accidents and incidents that took place within the service were not reported to the Care Quality Commission or the local authority safeguarding team as required. We found a number of incidents had not been investigated and action had not been taken to prevent their future reoccurrence.

People were not always consulted before care tasks were carried out and we witnessed episodes of poor care during the inspection.

People's medicines were not always administered as prescribed. Some people were prescribed medication to reduce their levels of anxiety; we found that the service did not have instructions for staff to follow as to when this medication should be given.

There was not enough staff to meet the assessed needs of people who lived at the service. The registered provider did not have accurate and up to date records of what training staff had completed. Staff told us they did not feel supported by the registered manager.

An adequate quality assurance system was not in place which would highlight the shortfalls within the service. When feedback was received from people who lived at the service and their relatives via satisfaction surveys and complaints, it was not clear what action the service had taken to improve.

Breaches were found in regulations 9, 10, 11, 13, 18, 22 and 23 we have deemed this was a major risk to people who lived at the service. You can see what action we told the registered provider to take at the back of the full version of the report.

Summary of findings

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 abuse and avoidable harm. Care plans did not provide adequate guidance to enable staff to manage people's behaviours that challenged the service and other people who lived there. Incidents were not reviewed or reported as required.

There was not enough staff to meet the needs of the people who used the service.

Guidance was not available for staff to follow when administering medication on an 'as required' basis.

Is the service effective?

Inadequate 

The service was not always effective. Staff did not have the skills or knowledge to work with people with learning disabilities and to communicate with them effectively because they had not completed appropriate training.

Staff understood how to gain consent from people but we witnessed care and support being delivered without consent being gained and the principles of the Mental Capacity Act (2005) were not followed.

People were supported to eat a balanced and healthy diet. When concerns over people's weight were highlighted, relevant professionals were contacted for their advice and guidance.

Is the service caring?

Requires Improvement 

The service was not always caring. We witnessed people being treated with dignity and respect by staff. However we also witnessed episodes of poor care.

Staff knew people's personal histories and their preferences for how care should be delivered.

People's freedoms were restricted and they were not supported as required. One person told us staff were not interested in their health problems.

Is the service responsive?

Inadequate 

The service was not responsive. People did not have all of their needs assessed, recorded and reviewed.

People were not given the support and care they required to meet their needs.

Some people did not know how to make a complaint and when feedback was received it was not clear what action had been taken to address people's concerns.

Summary of findings

Is the service well-led?

The service was not well led. The registered manager lacked awareness and was not fully involved of the day to day running of the home.

Care Quality Commission requirements, including the submission of notifications, were not met.

A quality assurance system including audits and quality monitoring was in place but it was not effective in highlighting issues within the service.

Inadequate

Berkeley House

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 12 December 2014 and was unannounced. The inspection team comprised of three adult social care inspectors an inspection manager and a specialist professional advisor (SPA). The SPA had experience of working with people with learning difficulties.

Before the inspection took place, we were contacted by the local authority safeguarding team. They informed us that incidents including abuse or allegations of abuse may have taken place within the service that we were not notified of. We also spoke to the commissioners of the service to gain an understanding of their views in relation to the service.

During the inspection we spent time observing how staff interacted with people who lived at the service. We spoke with six people and four relatives. We also spoke with the registered manager, the head carer, three senior carers, the principal senior, the quality manager, the training manager, the operations manager and 10 members of care staff.

We looked at 10 care plans and records relating to people who lived at the service including their pre-admission assessments and medication administration records (MAR). We also looked at a range of documentation relating to the management of the service including, audits, staff rotas, minutes from meetings, questionnaires, four recruitment files and staff training records.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe, "Yes I do feel safe", "It's safe here" and "Yes, we are all safe, the staff tend to our needs and come when we call for them." People also said, "Sometimes you do have to wait (for a member of staff) but that's because they are so busy", "I get my tablets on time" and "They look after my medicines, I've got so many pills and creams I'd never remember when to take what." However, we looked at records and spoke with staff and judged the staffing levels were insufficient to meet people's needs in full.

A visiting relative told us, "I think she is safe here; you can't just walk in, they have to buzz you in so they always know who is in the building." Another relative said, "I know mum has dementia and she is often talking about another time and place but the staff don't seem to have the time to just sit and talk with her."

People who lived at the service were not always protected from abuse and avoidable harm. We found that accidents and incidents were not always investigated. We saw that between 13 February 2014 and 4 December 2014 there had been 28 incidents of violent or aggressive behaviour when people who used the service had assaulted members of staff. Investigations and staff de-briefing had not taken place and lessons had not been learnt by the registered provider. Care plans, behaviour management plans and risk assessments had not been updated after each incident to reduce the possibility of their future re-occurrence. Failing to learn from incidents that resulted in harm to members of staff meant that the service had not developed the skills to de-esculate people's behaviours which resulted in people who used the service being involved in violent and aggressive incidnets with other vulnerable people. Body maps relating to people who lived at the service had been completed by staff showing high numbers of bruises, scratches and other marks on people's bodies which had not been investigated or reported to the local authority safeguarding team or the Care Quality Commission as required. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

Records showed that 74% of staff had completed training in relation to safeguarding adults from abuse. During discussions, staff were knowledgeable about the different types of abuse that could occur and what actions to take if they suspected it had occurred. A member of staff we spoke with said, "I've reported things to the safeguarding team in the past but not whilst working here." Another member of staff said, "It's about keeping the residents safe from harm, from their own decisions sometimes" and "One resident can be violent and aggressive, we have to move the other residents away and use distraction techniques and PRN medication when it happens."

Behaviour management plans had been developed for a number of people who lived in the Berkeley Bungalows however, they lacked insight and depth. They were produced for staff to follow when people displayed behaviours that challenged the service but had not been updated as people's behaviours increased in frequency and aggression. One plan stated, 'I need staff to give me my own space and recognise the signs when I am becoming angry'. It did not provide information in relation to what signs staff should look out for that would indicate when the person was becoming angry. It also stated, 'I need staff to realise when I am becoming agitated and leave me alone to calm down; if I become too agitated please give me my PRN medication'. PRN is the abbreviation used to describe when medicines are 'as required'. It did not state what signs would be displayed as the person's agitation elevated or what 'too agitated' looked like so staff would know when PRN medication was required. We asked the registered manager for the PRN medication protocols used by staff to recognise when PRN medication was required, the registered manager told us that no protocols had been created so there was no guidance for staff. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

We checked the recruitment records for three members of staff employed by the service. The registered manager told us that staff were only employed after suitable references had been returned and an appropriate disclosure and barring service (DBS) check had been received. However, we saw that one member of staff had been dismissed from their last employer; there was no evidence to show that this had been considered before the person commenced working within the service or that it had been discussed with the employee.

Inadequate

Is the service safe?

During the second day of the inspection, we observed the lunchtime experience on the dementia care unit. We saw people who used the service had to wait for long periods to be assisted with their meal. We were asked by a number of residents if we could help them to eat their lunch because they were hungry. One person was moved and assisted into a wheel chair by two members of staff which left 16 other people to be supported by a senior member of staff and an agency worker which is not adequate. The senior member of staff told us, "They (agency worker) always slow us down, as we have to tell them what to do all of the time." We asked the registered manager how they assessed the staffing levels within the home and were told, "We know the level of care they need from the pre-admission assessment." The registered manager told us they did not use any form of tool to assess people's individual needs and confirmed there was no formal monitoring of the current staffing levels in place.

We asked the registered manager if they could show us an example of when staffing levels had been increased as people's needs changed and were told, "I don't have any evidence that staffing on the dementia unit has ever been increased." The nominated individual told us that the registered provider was developing a new staffing tool that would be implemented in the near future. At the time of the inspection, appropriate steps had not been taken to ensure that people who lived at the home had their needs met by sufficient numbers of appropriate staff. A member of staff told us, "I usually have to work from 10am to 10am (this included a sleeping in shift) the following day and have no choice. It's very tiring especially when there have been incidents" and "We should have 20 staff and currently have six, this means staff have to work long hours or agency workers are used." This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

We looked at the way medicines were managed within the service. We found Berkeley House staff ordered, administered or destroyed medicines safely. A dedicated medicines room was used for the safe storage of medication; this included medication trolleys, a medication fridge and a controlled drug cabinet. We checked several medication administration records (MAR) and saw that they were completed accurately. When we checked the service's controlled drug (CD) book we found there to be several errors in recording with incorrect dates, we also saw that on two sepertae occasions only one person had signed the CD book when a CD had been administered.

The storage facilities within the bungalows were appropriate; cabinets were secured as per best practice guidance. However, medication was not ordered, stored and disposed of appropriately. We noted large quantities of over stocked items that had not been disposed of or returned to the pharmacy, we also found numerous single tablets stored in envelopes with no records to what the medication was or why it was being stored in this way. We checked a number of MAR and found issues with recording and administration, for example topical creams were being used and not recorded on a MAR or body map. We saw that people's medicines were not always given as prescribed, for example one person had a detailed plan produced to manage their constipation but when we checked their MAR they had not been given the required dosage to support their needs. A number of people had been prescribed PRN medication to lower their levels of anxiety as required. There were no protocols in place for when this medication should be administered or the length or time between each dose, which could lead to people being over medicated. For example, one person was given PRN medication on 7 June 2014 at 2.20pm and 3.20pm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

Inadequate

Is the service effective?

Our findings

People told us they enjoyed a healthy nutritious diet and chose what meals they wanted to eat on a daily basis. Comments included, "The food is lovely", "You can choose what you want, they bring us the menu's and they write down what we want", "The staff cook and on Sundays we go over there (to the main building) and have a roast" and "Fridays are my favourite because we get fish and chips."

We spoke with the registered provider's learning and development manager and were told, "Training needs to be improved, at the moment we have a system that is still being developed so it's not always easy to see what training people need." The nominated individual told us, "We should be able to see instantly what training staff have completed but obviously we can't."

We looked at incident records that had occurred within the bungalows. One record stated that a person who lived at the service was displaying behaviour that challenged the service; because of the severity of the behaviour the member of staff locked themselves into the staff office. A member of staff we spoke with said, "Sometimes you have to get away from (name of person using the service), they also said, "Pulls our hair, grabs hold of you, it happens to me loads." This is not an effective way to manage people's behaviours and puts other people in the service at risk. We looked at training records and saw that staff had not been trained to effectively manage behaviors that challenged the service and others.

The registered manager told us the service had two training matrixes; one for staff who worked in Berkeley House and one for staff who worked in the bungalows. This was because the bungalows care for people with learning disabilities so staff needed specialist training. We looked at the matrix for staff who worked in the bungalows and saw that only 38% had completed training specifically designed to care for people with learning disabilities. Only 57% percent of staff had completed training in how to manage challenging behaviour including violence and aggression and only 62% had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS).

The registered provider's supervision planner stated, 'formal supervisions must take place a minimum of six times a year for each staff member'. We saw this had only been achieved for two members of staff. We asked the registered manager if the documentation we had been supplied with was accurate and were told, "Yes the planner is up to date, it looks like the senior staff who should carry out supervisions were not doing what they should have been." A member of staff we spoke with said, "We don't really have that many meetings anymore and I can't remember the last time I had a supervision." Failing to ensure staff are adequately supported and are being provided with a forum to discuss their concerns and training needs led to care staff not having the appropriate skills to meet the needs of the people who lived at the service. Staff we spoke with told us they did not feel they had completed relevant training to ensure they could meet people's needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

The Care Quality Commission is required to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when a person who uses the service lacks capacity and the care they require to keep them safe amounts to continuous supervision and control. DoLS ensure where someone is deprived of their liberty, it is done in the least restrictive way. At the time of the inspection no DoLS authorisations were in place and no applications had been made. We spoke with the head carer and were told, "We have had training recently but I do still find it confusing, I am working on people's applications at the moment." We also spoke to the registered manager about their understanding of the Mental Capacity Act and DoLS and we found this to be lacking.

The service has a dementia unit which is on the second floor; access is gained via a passenger lift or a stair well that requires a key pad code. One person on the dementia unit was observed stood by the lift with their coat on. The person was told that they were not allowed in the lift and had to remain on the dementia unit. A senior carer told us, "We can't let him off the unit because he gets confused and it would not be safe for him to wander about." A DoLS had not been considered for this person and when we checked their care plan there was no evidence to show that restricting the person's movements to the dementia unit was the least restrictive option.

In the care records we looked at we saw people's capacity had been assessed by a local mental health trust before they moved in to the home and was documented in their

Inadequate

Is the service effective?

pre-admission assessment. However, we saw that the assessments had not been reviewed and they had not been formulated into a care plan. This did not adhear to the principles of the Mental Capacity Act (2005) and it was not clear that this was the least restrictive intervention.

During conversations staff described how they would gain consent from people before care was delivered. However, we witnessed episodes of poor care when staff failed to interact with a people or gain consent before care was provided. For example, one person who had requested to be taken to the toilet had their chair pulled back away from the table from behind and no explanation was given before this was done which visibly upset the person. This showed us that staff did not always seek people's consent or permission before consent was gained. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

People were supported to maintain a balanced and healthy diet. Portion sizes were altered to suit people's individual preferences and we saw that people were weighed on a regular basis so any trends in weight loss or gain could be identified. We spoke with a speech and language therapist who was visiting a person who lived in the home at the time of the inspection. We were told, "They (the staff) are pretty good, if anyone loses weight or is struggling to eat they contact us straight away. The person I have seen today is doing really well and that's down to the staff."

We observed a person living on the dementia unit sitting at the dinner table 30 minutes before lunch was due to be served. We asked the person what they were having for their lunch and they told us they didn't know. A senior member of staff said that the person had chosen their meal the day before and must have forgotten what they had ordered. The service did not have pictoral aids displaying what meal time choices were available which would be an effective way to remind people what food was on offer and remind them of what choice they had made.

People's health and social care needs were met by a multi disciplinary team of healthcare professionals. We saw the GPs, community nurses, mental health nurses, consultant psychiatrists, speech and language therapists and the fall team had input into people's care. A senior member of staff told us, "We work with other professionals and follow their advice to make sure we deliver the best level of care we can." A visiting relative said, "Mum fell a couple of times and they got the doctor out straight away. They got her a special (sensor) mat for her room so they know when she is trying to walk around." However, we found that the service did not always follow professional advice. Behaviour management plans had not been developed and staff had not been trainined as advised by a local mental health trust care plan.

Requires Improvement

Is the service caring?

Our findings

People told us they were supported by staff who knew them well and understood their individual needs. One person said, "The staff are nice but I have my favourites, I speak to (name) about my family and she tells me about hers" and "They know what support I need and what I like to do for myself, that's what I like about it here, I still get to do things myself." Another person told us, "I like it here, I've made loads of new friends", "The carers are really nice" and "I like what they do for me and there are lots of parties here." A person who lived in the bungalows confirmed staff knocked on their bedroom door before entering and said, "I'm alright in the shower or the bath staff don't just come in."

People also told us, "The staff don't have time to sit and talk to me, sometimes I just want a chat but they don't have the time" and "I'm well looked after and well fed but I do wish that the girls (the staff) could spend more time talking about the old days."

During the inspection it was evident that staff were busy and this lead to a more task orientated approach. One person had not eaten their evening meal and when we asked if they didn't like it they told us they had issues with swallowing and could not eat their food. We asked if they had told the staff about this and they said they hadn't bothered because the staff wouldn't be interested and didn't have the time to support them. This was witnessed by the registered provider's nominated individual.

We were asked by a person who used the service to help them and when we asked care staff to assist, we observed them take hold of the person's legs and clothing to see if they had been incontinent of urine. This was carried out without any form of discussion or prior warning, this was done in a main lounge and showed no consideration for the person's dignity. A second person who had requested to be taken to the toilet had their chair pulled back away from the table from behind and no explanation was given before this was done which visibly upset the person.

We observed staff interacting with people who lived at the home. It was evident staff knew people's personal preferences for how care and support should be delivered. Staff spoke to people in a relaxed and friendly manner and encouraged people to take part in group activities such as quizzes and singing. A person who lived at the service told us, "Some children from the local school are coming to sing Christmas carols today, I can't wait."

People were enabled to maintain their independence. A member of staff told us, "We try and encourage people to be as involved with things as they can be, one lady helps us set the tables before lunch and tea, a man helps with the gardening in the summer and a few of the ladies gave instructions about the Christmas decorations. You have to let people do what they can."

People were involved in planning their care when possible. A visiting relative told us, "We have regular meetings about how things are going and we can talk about anything that we want improving but we are really happy with the care." We saw that end of life decisions had been made by a number of people who lived at the home and care plans had been produced that contained information such as people's wishes and preferred place of care.

We asked staff how they promoted people's dignity and showed them respect. One member of staff told us, "I always ask if it's ok for me to do something, like providing personal care or helping people to get dressed" and "There is a bit in the care plans about what support people want and what they do for themselves so it's good to know that." A second member of staff said, "I listen to what they are saying and I do what they ask, I don't rush people and keep private things private." A visiting relative told us, "They are so good to her and everyone else, the staff are great." Another member of staff said, "They have their own bedrooms, we knock on doors, they are expected to do this to each other as well" and "You have to be polite to people and ensure they have a say, lead their own lives – I'm just here to help."

We asked the registered manager if there were any restrictions on visiting times and were told, "We let people visit whenever they want to." A visiting relative told us, "You can visit whenever you like, I come as often as I can and no one has ever tried to say it's too late or I have to leave."

Inadequate

Is the service responsive?

Our findings

People who used the service told us they knew how to make complaints and were encouraged to maintain relationships with people who were important to them. They told us, "I would just tell the manager if I was unhappy about anything", "I would just tell the girls if I had any problems, I have spoken to them before about someone who was being too loud and they asked the person to quieten down a bit", "My boyfriend comes down some nights and I see him at the pub, sometimes we have time on our own" and "My sister comes to see me and I go out with her to town sometimes."

We saw evidence to confirm that some people who lived at the service had their care needs reviewed on a periodic basis. However, it was apparent that not all of people's needs were assessed or planned for. A number of people who lived at the service had displayed behaviours that challenged the service and other people. In one case a behaviour management plan had not been developed to provide guidance and support for staff. Another two people had behaviour management plans in place but they lacked depth and failed to provide adequate guidance to staff. As people's behaviours increased in intensity and frequency, we saw care plans had not been updated or reviewed. ABC's (antecedent behaviour charts) were in place for two people but they had not been reviewed and there was a lack of understanding as to why they were being completed.

We looked at the pre-admission assessment for one person who lived in the bungalows. The assessment stated the person had specific communication needs associated with their learning disability. A communication support plan had not been developed that provided examples to aid staff to communicate effectively with the person and no training had been undertaken to educate staff in this area. A second person's pre-admission assessment stated they could use Makaton but may need re-skilling to be able to communicate effectively and that they would make sounds to express how they were feeling. A communication support plan had not been developed indicating what different sounds meant or what Makaton signs the person could use. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

The care files we looked at showed that people and/or their relatives were involved in the initial care needs assessment and in the formulation of their care plans. Care plans had been produced that contained information people's life histories. These included family members and other people who were important to them, where they had lived and worked and their hobbies and achievements. People who lived in the bungalows had care plans produced in an easy read format. We noted 'what is important to me' and 'how best to support me' documents had been developed which helped to ensure people received care and support in a way that was preferable to them and allowed them to remain independent.

People were supported to follow their personal interests and encouraged to develop new skills. One person who lived in the bungalows had been supported to attend Mathemathics and English classes and volunteered in a charity shop once a week. A member of staff told us, "(Person who used the service) used to go to church on Sundays but now doesn't go now as he says it's boring" and "Goes out independently and does what he wants."

Reasonable adjustments had been made to the building to support people's needs. These included a passenger lift, wide corridors for wheelchair use, hand rails to aid independent mobility and a security door at the main entrance. The dementia unit had been decorated in a dementia friendly way. A sensory room had been developed that included different textured walls and a florist style market stall display. Memory boxes were displayed outside people's rooms to help orientate people and allow them to find their room easily. We witnessed one person engaged in doll therapy; doll therapy is seen as a purposeful and rewarding activity which can reduce people's levels of anxiety.

The service had a complaints policy in place that detailed how a complaint could be made and the expected timescales for a response. We saw that an unannounced visit form the registered provider's operations team on 10 November 2014 highlighted two complaints had been received by the service but had not been investigated. We highlighted this to the registered manager who confirmed they would address this as a matter of urgency. This demonstrates that complaints were not used to improve practice or develop the service.

A member of staff we spoke with told us, "They (the people who lived at the home) know how to make a complaint,

Inadequate

Is the service responsive?

(name) goes to see the manager if he is not happy about anything." A relative we spoke with told us, "I have complained in the past but not a lot was done about it so it makes you think there isn't any point (in complaining again)."

Inadequate

Is the service well-led?

Our findings

The service was not well led. There was a registered manager in post who had registered with the Care Quality Commission to manage the service. However, the service was not managed effectively which led too numerous concerns being found during the inspections and breaches to regulations 9, 10, 11, 13, 18, 22 and 23 which we deemed had a major impact on people who lived at the service.

Members of staff told us, “It’s not the most supportive place to work, we don’t have supervisions or have meetings very often”, “I’ve only had one supervision since I started and didn’t really get a proper induction” and “We record all the times when (Person who used the service) is violent and aggressive and the manager see’s them but nothing gets done; it’s like if we get hit or our hair pulled out it doesn’t matter.”

At the time of the inspection a registered manager was in post. It was clear that the registered manager and staff did not share an understanding of the key challenges and risks within the service. We asked the registered manager what was being done to manage the incidents and challenging behaviour of some of the people who lived in the bungalows and were told, “I don’t know, that’s what I pay a principal senior for.” Members of staff we spoke with said, “The manager doesn’t have a clue what’s going on in the bungalows”, “There is no support offered by the manager” and “The manager does not look at anything in the LD unit (bungalows).” Incidnents of violent and aggressive behaviour had not been investigated. This meant that staff were not de briefed and lessons were not learned to improve the service which led to more incidents taking place and people suffering from abuse and harm which could have been avoided.

Prior to our inspection we were informed by the local authority safeguarding team that they had become aware that incidents and allegations of abuse had not been reported as required to themselves or the Commission. It is a legal requirement for us to be notified about these events, so that we can monitor services effectively and carry out our regulatory responsibilities. We asked the registered manager why the incidents of aggressive and violence between people who lived at the service had not been reported and were told, “I haven’t seen all the incidents and I can’t report what I don’t know about.” This showed us communication systems had not been effective as the registered manager was not fully aware of incidents which were occurring in the service. The registered manager failed to notify the commission of the abuse or allegations of abuse of a person who used the service. Staff told us that when incidnets occurred within the bungalows the registered manager was informed and failed to take action.

We spoke with the Nominated Individual, Director of Operations and the Chief Executive Officer who were not aware of the incidents that had taken place within the bungalows. The Chief operating officer told us, “We have a system in place so that when high level incidents take place they are reviewed by the senior team. We have not reviewed the actions taken for any of the incidents from the bungalows because we were not made aware of them." The registered had failed to follow the reporting procedures of the registered provider.

We saw evidence that people who used the service and relatives had been involved in meetings which were held periodically. Topics discussed included changes to the menu, future activities and visits from local school children to sing Christmas carols. Satisfaction surveys were sent out on an annual basis from the service. We saw that people who lived at the service were asked for their opinions in January 2014 and a relatives survey had been sent out by the registered provider in September 2014. 32% of responders stated they were unsure of the service’s complaints policy and 44%percent stated they were not sure if suggestions in residents and relatives meetings were followed up. It was not clear what actions had been taken to address either of these areas.

There was a system in place to monitor the level of service provided. A range of audits were completed on a regular basis including, care plans, the environment, laundry, kitchen, maintenance, admissions, domestic hygiene, health and safety, fire safety and infection prevention and control. A water sample had been taken to check for legionella. The care plan audit we saw acted more as a check list to ensure certain aspects had been completed and did not comment on the level of detail or quality of the care plan. They had not identified behaviour management plans were not in place for people who displayed challenging behaviours or that protocols for when people needed, ‘as required’ medicines had not been developed. Unannounced visits form the registered provider’s operations team had taken place four times in 2014 which

Inadequate

Is the service well-led?

also failed to highlight these issues. This meant the audit system was not effective. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the registered provider to take can be found at the back of this report.

The registered manager failed to ensure that a suitable system was in place to highlight shortfalls within the service. Including staff not receiving supervisions in line with the registered provider's policy, not having a clear understanding of what training staff had completed, what had expired and what needed refreshing and a failure to investigate accidents and incidents and learn from them to improve the quality of the service.

We saw resident meetings and relatives meetings were held periodically and used as a forum for people to discuss any issues they had or raise concerns. A member of staff confirmed meetings were held. However we saw that when feedback was received actions were not taken to improve the service. A visiting relative we spoke with said, "I don't even bother trying to speak to the manager about anything because I've tried to discuss things more then once but they don't care."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. How the regulation was not being met: People who used the service were not protected against the risks associated with medicines. People did not always receive their medicines as required. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to Care and Treatment. How the regulation was not being met: People's consent was not always gained before care and treatment was provided. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. How the regulation was not being met: There were not sufficient numbers of suitably qualified, skilled and experienced persons deployed within the service. Regulation 22.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff. How the regulation was not being met: Staff did not always receive appropriate training, professional development, supervision and appraisal. Regulation 23

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People who used the service were not protected against the risks of inappropriate or unsafe care and treatment because an effective system was not in operation to enable the registered manager to assess and monitor the quality of the service. Regulation 10 (1) (a) (b) (2)

The enforcement action we took:
We have deemed this had a major impact on people who used the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who used the service were not protected against the risks of receiving inappropriate care. Care plans and other associated documentation did not contain accurate and up to date information to guide staff in meeting people's needs. Regulation 9 (1) (a) (b) (i) (ii)

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met: People were not safe. Behaviours that challenged the service were not managed effectively. Care plans and behaviour management plans were not updated after violent and aggressive incidents. Regulation 11 (1) (a) (b) (2)

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.