Care Quality Commission

Kalbro Investments Limited

Eleanor House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected Eleanor House on 6 and 7 July 2015. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

Eleanor House is registered to provide accommodation and personal care with nursing for 17 adults who may be living with mental health or dementia related conditions. Accommodation is located on the ground and first floors, with both shared and single rooms. There is lift and stair access to the first floor. The service is situated close to local amenities.

The manager of the service became the registered manager on 13 May 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 8 and 9 January 2015. During this inspection we found the registered provider was in breach of regulations 9, 10, 11, 15, 17, 18, 22 and 23 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010. These relate to Regulations 12, 17, 13,

Summary of findings

15, 10, 11 and 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. This meant that the registered provider was not meeting the regulations relating to safeguarding people who used the service from abuse; ensuring staff respected people who used the service and involved them in their development of their care and treatment; ensuring treatment or support was delivered in line with people's needs; ensuring consent from people or appropriately appointed persons was obtained; ensuring sufficient numbers of qualified, experienced and skilled staff were in place; ensuring staff received adequate training and support and assessing and monitoring the quality of service provision.

We also found a breach of regulation 18 of the Care Quality Commission [Registration] Regulations 2009 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010. This meant the provider had failed to notify us of incidents occurring in the home.

We undertook a focused inspection on 6 and 7 July 2015 to check whether the service was now meeting legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eleanor House on our website at www.cqc.org.uk.

During this inspection we found that since the inspection in January 2015 the registered provider had implemented a range of audits and checks; however we found these were ineffective and failed to highlight shortfalls within the service.

We found that the registered provider had continued to fail to take appropriate action to recruit additional staff to ensure there were sufficient numbers deployed within the service.

We saw that the registered provider had taken action to ensure staff had received training about the Mental Capacity Act [MCA] 2005. However, we found that where people lacked capacity staff continued to fail to adhere to the MCA Code of Practice. Staff did not understand the principle that people needed to be able to make decisions including unwise choices. Staff did not explore the strengths people who used the service had and therefore were not supporting individuals to make decisions. Also staff failed to ensure, when appropriate, that 'best interest' decisions were made. Staff had not always had regard for the professional code of conduct in relation to the MCA when administering covert medicines.

We found that the registered provider had developed people's care records but more work was required on these to ensure they provided staff with accurate information to enable to them keep people safe.

We found that the registered provider had taken action to ensure staff knew how to report safeguarding concerns. Staff had received training to ensure they knew how to manage the behaviours that may challenge the service. However, more progress and evidence of sustained improvements was required. We found that the registered provider remained non-compliant with this regulation.

We saw that the registered provider had taken some action to ensure people were provided with an environment that was safe. However, more work was required on the electrical wiring of the building to ensure the registered provider became compliant with this regulation.

During our focused inspection we saw that the registered provider had taken action to enable people's involvement in decisions and promotion of their wellbeing. However, more progress and evidence of sustained improvements was required to ensure the registered provider became compliant with this regulation.

We found the registered provider had taken action to ensure staff had the right skills to carry out their roles. However, more progress and evidence of sustained improvements was required to ensure the registered provider became compliant with this regulation.

Since the inspection in January 2015 the registered provider had taken action to ensure notifications about significant incidents were reported correctly. However, more progress and evidence of sustained improvements was required to ensure the registered provider became compliant with this regulation.

We have judged these latest findings demonstrate the breaches of regulations continue to have a major impact on the people who used the service. This is being followed up and we will report on our action when it is complete. As a result of the continued non-compliance we are considering our regulatory response.

Summary of findings

The registered provider has given us written assurance they will not admit any further people to the service until we are satisfied appropriate arrangements are in place to ensure people's health, safety and welfare are protected and the registered provider is compliant with all of the relevant regulations.

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.

The assessment and planning of people's care and support was not carried out sufficiently to ensure staff had accurate records to enable them to protect people from potential risk and safeguard them from harm.

Staff had received training to ensure they could recognise and knew how to report incidents of potential abuse; however there were insufficient numbers of staff available to ensure people were supported safely.

Some progress had been made to ensure the building was adequately maintained, but further work on this was required.

Is the service effective?

Inadequate 

The service was not effective.

Further training was required to ensure staff had the skills and knowledge about people's needs to enable them to be supported effectively.

Whilst staff had received training about the Mental Capacity Act [MCA] 2005, they continued to fail to apply the principles of the MCA and adhere to the MCA Code of Practice.

Is the service caring?

Requires improvement 

The service was not always caring.

Whilst some improvements had been made to enable the involvement and participation of people who used the service in planning their support; further progress and evidence of sustained improvements to ensure the dignity and privacy of people was required.

Is the service responsive?

Inadequate 

The service was not always responsive.

People's needs were not fully assessed and care was not planned and documented to enable their wellbeing to be promoted.

The provision of meaningful activities required further development to enable the wellbeing to be developed.

Is the service well-led?

Inadequate 

The service was not well led.

The quality assurance systems implemented since our last inspection, were not effective and lacked the depth to drive improvement.

A registered manager was now in place.

Summary of findings

Notifications about significant incidents were now being reported appropriately.	

Eleanor House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Eleanor House on 6 and 7 July 2015. This inspection was carried out to check whether improvements to meet legal requirements had been made after our comprehensive inspection on 8 and 9 January 2015.

The first day of the inspection was carried out by two adult social care inspectors, a specialist advisor with a background in mental health and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was undertaken by two adult social care inspectors.

Before our focused inspection we spoke with the local authority safeguarding and commissioning teams and reviewed information that was sent to us by them and the fire service, together with data we hold about the service.

We used the Short Observational Framework for Inspection [SOFI] in the communal areas of the service. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We talked with five of the people who used the service, a member of domestic staff, three members of care staff, a bank nurse who was on duty and the registered manager. We also spoke with three visiting relatives, a community based specialist professional who had regular contact with the home, a district nurse who was visiting and a GP.

We looked at six care files which belonged to people who used the service. We also looked at other important documentation relating to people's assessments about their capacity to make informed decisions. We checked whether best interest meetings for people who lacked capacity were held to enable important decisions to be made on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included seven staff recruitment files, training records, the staff rota, minutes of meetings with staff and those with people who used the service, quality assurance audits and maintenance of equipment records. We completed a tour of the premises to check if the environment was clean and safe.

Inadequate

Is the service safe?

Our findings

Whilst people who used the service told us they felt safe and were happy with the support they received, we found there were continued multiple breaches of regulations which meant there were risks to their health, safety and welfare.

At our comprehensive inspection of Eleanor House on 8 and 9 January 2015, we found that care and behavioural management plans were not descriptive enough to support staff to deliver safe care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 9 and 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our focused inspection 6 and 7 July 2015 we found that the registered provider had not taken appropriate action to meet the shortfalls in relation to the requirements of Regulation 9. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response.

Following the comprehensive inspection we told the registered provider to take action regarding the development and implementation of descriptive, specific and informative care plans that would enable staff to meet people's assessed needs and manage behaviours that challenged the service in a consistent way. During this focused inspection we found new care and management plans had been developed; however they failed to provide insight into people's specific needs and contained inadequate guidance to enable staff to manage people's behaviours.

A 'behaviours that challenge the service' care plan had been written for one person who used the service; the care plan stated, 'staff to try and calm me down in a professional manner' and 'staff do need to monitor my behaviour using techniques learnt'. There was no guidance informing staff on what actions were effective to calm this person, or at what stage diversionary techniques should be used. Although monitoring of the person's behaviour had been highlighted as being required there was no guidance on how this should be completed and we saw that no formal recording about this was taking place.

An 'invading others personal space and inappropriate touching' care plan was in one person's care plan which stated, 'staff to closely monitor [Name] and remind him whenever he acts inappropriately'. The care plan lacked insight into the precursors to the person's 'inappropriate touching' and provided no guidance for staff about what was appropriate and what was inappropriate, this could lead to people's behaviours being managed in an ineffective and inconsistent way.

We found that the care plans developed to meet the needs of one person who used the service contained contradictory information. For example; a care plan titled 'invading others personal space and inappropriate touching' stated, 'I go out with two members of staff in public to make sure I do not upset other people'. A 'being out in the community care plan stated, 'at times when I am settled I can maybe go out with out with one member of staff' whilst a 'verbal and physical aggression to others with actual assault' risk management plan stated, 'when in public [Name] is to be accompanied by two experienced members of staff'. This contradictory information could lead to the person not being supported effectively and indicates that the registered provider is not fully aware of how to meet the person's needs.

A 'verbal and physical aggression to others with actual assault' risk management plan stated, 'explain to [Name] his behaviour is unacceptable, use de-escalation techniques [see care plans 1 and 3]' and '[Name] is to be accompanied by two experienced members of staff [see care plan 5]. There were no de-escalation techniques described in care plans 1 and 3 and care plan 5 was for foot care and contained no information about support in the community. Failing to provide information to staff to follow when managing risks could lead to people receiving in-appropriate and ineffective care that does not meet their needs.

We found that care plans had not been developed to meet people's specific needs; a risk management plan was in place for one person who used the service titled, 'Inappropriate over friendly behaviour towards children'. However, a care plan had not been developed to mitigate this identified risk or to provide guidance to staff what was appropriate and what was inappropriate behaviour. A 'mental health issues' care plan was in pace for one person which stated, 'I get stressed by the voices I hear, I would like staff to help me cope'. The care plan lacked insight into the person's mental health needs and failed to provide adequate information for staff to support the person

effectively. The registered manager told us, "I don't know how many voices talk to [Name] or what they tell her to do. We really don't know very much about it, apart from to comfort her and listen if she wants to talk to us."

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 9 and 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our comprehensive inspection on 8 and 9 January 2015, we found incidents of violent and aggressive behaviour were not reported to the Commission or the local authority safeguarding team as required. This was a breach of Regulation 11 of the

Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which relates to Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014

At our focused inspection on 6 and 7 July 2015 we found that the registered provider had taken action to meet the shortfalls in relation to the requirements of Regulation 13. However, more progress and evidence of sustained improvements was required to ensure compliance with this regulation. We are currently considering our regulatory response.

At our comprehensive inspection on 8 and 9 January 2015 we found records that provided evidence that staff had physically restrained one person who used the service to provide them with personal care. A restraint or physical intervention care plan was not in place and staff had not completed training to enable them to restrain people safely. During this focused inspection we reviewed all of the accident and incident records and found no evidence that restraint or physical intervention had been used. The registered manager told us, "That incident was a one off, we would not and do not restrain people."

During this focused inspection we found that when an incident occurred or an allegation of abuse was received, the registered provider took appropriate action. The registered manager told us, "Every time something happens it gets recorded and I will either investigate it internally or report it to safeguarding team and follow their instructions." We saw evidence to confirm internal investigations took place and the findings were used to develop the level of service provided. The registered provider had taken corrective action after an incident had occurred within the service which included, amongst other things the suspension of a member of staff whilst the investigation was being carried out.

During our focused inspection on 6 and 7 July 2015, we saw that staff had completed training in relation to the protection of vulnerable adults from abuse and also attended a recent session on the management of challenging behaviour that was delivered by an external provider. Staff told us how they used de-escalation and distraction techniques to minimise potential incidents they witnessed. We found that staff meeting minutes contained evidence of discussions about the importance of safeguarding people from harm, including the responsibilities of staff to report issues of concern to enable them to be investigated.

During our focused inspection we found evidence that staff were not always recognising potential abuse or neglect. We found a person was being nursed in bed, due to the hoist for them being broken which was needed to lift them safely. We saw evidence the hoist had recently been serviced and were told that an engineer had been previously been requested for this, but so far no action had been taken to resolve this issue. We were concerned because the person's welfare and movements was restricted and placed them at risk of developing pressure sores. We raised a safeguarding alert with the local authority safeguarding team about this, as it highlighted potential neglect and a lack of awareness of potential harm and a need by the registered provider to have contingency plans in place.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which relates to Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are currently considering our regulatory response to this breach of regulation.

At our comprehensive inspection on 8 and 9 January 2015, we also found concerns relating to recruitment and employment practices followed for staff. There was a lack of evidence of the registered provider's decision making to not suspend a member of trained staff who was named in an allegation of abuse. We also had concerns relating to their decision to employ another member of trained staff who had been dismissed by their previous two employers. This was a breach of regulation 13 of the Health and Social

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Is the service safe?

Care Act 2008 [Regulated Activities] Regulations 2010. But also showed that the registered provider failed to take due regard of regulation 21 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010.

At our focused inspection on 6 and 7 July 2015 we found the registered provider had taken action to address the shortfalls in relation to the recruitment and management of staff. We found the registered manager had dismissed a further member of trained staff, for fraudulently providing information in their job application and reported this matter to their professional regulatory body. This showed us that concerns relating to the employment of staff were investigated and followed up when required.

We looked at seven staff files; we saw evidence to confirm staff were recruited safely. Before people commenced work with the service an application form was completed or a curriculum vitiate was provided, an interview took place and two references were returned to the registered provider. A disclosure and barring service [DBS] check was applied for to ensure the applicant had not been deemed unsuitable to work with vulnerable people.

At our comprehensive inspection on 8 and 9 January 2015 we found the safety of people who used the service was compromised because the registered provider had not ensured the building was adequately maintained. The meant there was a breach of regulation 15 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010.

At our focused inspection 6 and 7 July 2015 we found the registered provider had taken action to in relation to the requirements of Regulation 15. However, further work was required to ensure compliance with this regulation. We are currently considering our regulatory response.

Our findings included evidence confirming work had been completed to ensure the building complied with fire safety regulations and that other work was underway to upgrade the building. We found an action plan previously served on the registered provider on 7 October 2014 had been signed off by Humberside fire and rescue on 3 March 2015**.** Humberside fire and rescue service told us the actions taken by the provider in respect of this, had taken longer than anticipated, which meant they had needed to make a series of visits, before they were satisfied the service was now compliant with their regulations.

A member of maintenance staff had commenced work in the service since our last inspection. We saw evidence of work undertaken to ensure people who used the service were supported in an environment that was comfortable and safe. The maintenance staff told us they were implementing a programme of improvements to upgrade the building. They showed us evidence of regular checks they were now carrying out, including fire door safety checks and fire drills, together with environmental inspections to ensure the building was safe for people to use. They had installed temperature control regulation valves to hot water outlets to minimise potential risks to people from scalding. We found work was underway to redecorate and improve the lounge area and were told about other plans to improve the building further. People who used the service said they liked the improvements that were being made and told us they had contributed suggestions and ideas for the new colour scheme of the lounge.

Whilst checks of the environment were now being completed on a regular basis, we found some issues were not always reported in a timely manner. We heard the domestic cleaner asking for help from the maintenance staff, because a light bulb had shattered in a downstairs toilet. We saw an electrician was called out to remedy this fault; however the maintenance staff told this was a recurrent issue with three lights that regularly blew, due to issues with electrical wiring. The registered manager told us they had not been told about this previously. Similarly we found a pool of water on the floor in the downstairs toilet, due to a hand wash basin not being large enough to accommodate the pressure from the water outlet, which meant that water would overflow the basin. The maintenance staff told us about work they had carried out in relation to persistent dampness in the wet room, but told us they were uncertain how long this would solve the problem for as more work on this was required and new sealant was needed in several areas.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which relates to Regulation 15 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Since our last inspection a new domestic cleaner had been employed for 35 hours a week. The cleaner told us they had completed relevant training for their role, including

Inadequate

Is the service safe?

infection control, first aid and health and safety since the commencement of their work. We saw they were provided with adequate personal protective equipment and supplies. They were following a regular schedule of work to ensure the building was clean and tidy. We were shown work that had been recently completed in the laundry, with installation of new flooring and washable walls that made it easier to be cleaned and minimise risks of possible cross contamination.

At our comprehensive inspection on 8 and 9 January 2015 we found there was a lack of staff available to ensure people's needs were met at all times. This was a breach of Regulation 22 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010.

At our focused inspection 6 and 7 July 2015 we found the registered provider had not taken appropriate action to meet the shortfalls in regards to staffing; we are currently considering our regulatory response to this breach of regulation.

Following the comprehensive inspection we told the registered provider to take action to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff available at all times. This was to ensure people who used the service were provided with appropriate meaningful opportunities for social interaction and enable people requiring support from two staff to receive their care and support without having their freedoms and human rights restricted During this focused inspection we found whilst the registered provider had advertised for additional staff, their attempts to ensure there were always enough staff to enable people's needs to be safely met had so far proved unsuccessful. We found a dependency tool was now in use to enable the registered manager to assess how many staff were required. However, the effectiveness of this was limited, as we observed and saw from the rota that staffing levels had not changed since our last inspection.

We found there was a member of qualified staff available at all times, who was supported by two care staff to meet the needs of the 11 people who were using the service. The registered manager acknowledged they would like additional staff but told us, "We have tried advertising for staff, but this has proved to be very difficult." We found an agency was used to provide qualified nursing staff when this was required, but the registered manager advised they frequently provided cover themselves, to ensure a qualified member of staff was available at all times. This arrangement meant the registered manager was taken away from her own role at such times, which we found had impacted on their abilities to effectively carry out their managerial duties and ensure the service was fully compliant with regulations.

Care staff told us, "Nothing has changed; we are still short of staff at times." We saw the lack of staff was impacting on their abilities to meet people's needs. We found significant gaps in the recording in people's supplementary turn charts, which meant we could not confirm if they had received the support they required to keep them safe from harm. We found three people required support from two members of staff with moving and handling tasks or helping them to mobilise. This meant there was a potential that other people may be placed at risk of harm at such times. We were told arrangements were made to enable people requiring support from two members of staff to access the community, or for providing one to one support to be offered, but found these occasions were limited due to lack of staff cover.

This was a continued breach of Regulation 22 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which relates to Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Inadequate

Is the service effective?

Our findings

Whilst people told us, "Staff are great" and "They look after us", we found further training was required to enable staff to carry out their roles effectively.

At our comprehensive inspection on 8 and 9 January 2015 we found that specific guidance in relation to pressure care management was not implemented or adhered to. This contributed to the breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which relates to Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our focused inspection on 6 and 7 July 2015 we found that the registered provider had not taken appropriate action to meet the shortfalls in relation to the requirements of Regulation 9. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response.

Following the comprehensive inspection we told the registered provider to take action regarding the implementation of effective pressure care management. During this focused inspection we saw evidence to confirm that 'daily repositioning and skin inspection charts' were utilised by the service. The charts were in place to ensure people who were at risk of developing pressure sores were repositioned on a two hourly basis. However, we noted that on 27, 29 and 30 June 2015 and 1, 2 and 3 July 2015 the two hourly repositioning was not always recorded as achieved and there were numerous gaps in the records. The longest time between repositioning occurred on 1 July 2015 when a person was not repositioned for four hours. Failing to ensure people are repositioned could lead to the development of pressure sores and have a substantial impact on people's lives. The registered manager told us, "There is no reason why people shouldn't have been turned every two hours; I will look into why it has not happened."

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our comprehensive inspection on 8 and 9 January 2015 we found that staff were not supported effectively. This was a beach of Regulation 23 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which relates to Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014

At our focused inspection on 6 and 7 July 2015 we found that the registered provider had taken action to meet the shortfalls in relation to the requirements of Regulation 18. However, further progress and evidence of sustained improvements was required to ensure compliance with this regulation; we are currently considering our regulatory response.

Following the comprehensive inspection we told the registered provider to ensure staff were supported through supervisions and appraisals with their line manager. During this focused inspection we found that improvements had been made and the level of support staff received had increased. All staff had received an annual appraisal and had been supported during at least one, one to one meeting with the registered manager. The registered manager told us, "We have started with the supervisions; I have put a programme in place so all the staff, including the nurses will have six [supervisions] a year."

At the comprehensive inspection we found gaps in staff knowledge and skills; we reviewed the training records and found evidence to confirm staff training was not up to date. During this focused inspection we saw the registered provider had taken action to rectify this shortfall but further training was still required to ensure staff could meet the needs of people who used the service effectively.

Staff had recently completed training pertinent to their role including behaviours that challenge the service, pressure care management, end of life care, dementia, record keeping and person centred care. However, records showed that only eight staff had completed any form of mental health training even though the service provided care and support to people with mental health needs. When we checked the training certificates it became apparent that mental health conditions such as schizophrenia were not covered during the training. This meant that people who used the service with this condition would receive potentially ineffective care that did not meet their needs. A care plan had been developed for one person who used the service which stated the person had had a stroke and was at risk of reoccurrence. However, no

staff had completed stroke awareness training, which meant early warning signs may not be recognised and this could lead to people not receiving the care they required in a timely way.

This is a continued breach of regulation 23 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At the comprehensive inspection we had specific concerns relating to the care and management of people who had difficulties swallowing food, fluids and oral medications. At this focused inspection we found that a specialist nurse had provided gastrostomy training to the registered manager and a nurse. The specialist nurse told us they were satisfied with this arrangement, as the staff could disseminate this training to other nursing and care staff which would enable them to support people who had gastronomy needs effectively. The registered manager told us, "We are using a new training provider so the training is not all work books like it used to be, it's face to face and a lot more interactive now" and went on to say "The staff have said they prefer it like that."

We saw evidence to confirm that staff meetings took place on a quarterly basis or more regularly as required. The meetings were used as a forum for staff to raise concerns, discuss best practice and review the level of care provided within the service.

At our comprehensive inspection on 8 and 9 January 2015 we identified concerns that staff did not always have a clear understanding of their roles and responsibilities regarding people's consent to care and treatment. Also, the relevant requirements of the Mental Capacity Act [MCA] 2005 and Deprivation of Liberty Safeguards [DoLS]. This meant people's human rights were not properly protected. The Care Quality Commission is required by law to monitor the operation of Deprivation of Liberty Safeguards [DoLS].These safeguards are designed to protect the interests of vulnerable people and ensure they can be given the care and support they need in the least restrictive way possible. This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010.

At our focused inspection on 6 and 7 July 2015 we found the registered provider had not taken appropriate action to meet the shortfalls in relation to ensuring people were enabled to consent to their care or staff appropriately applied the requirements of the MCA. We are currently considering our regulatory response to this breach of this regulation.

Following the comprehensive inspection we told the registered provider to take action to ensure suitable arrangements were in place for obtaining and acting in accordance with, the consent of people in relation to their care and treatment. During this focused inspection we found some improvements had been made, such as the manager undertaking MCA training, applications submitted to the local authority for people's liberty to be deprived and assessments of people's capacity to make informed decisions and consent to their care and treatment that had been completed. However, we found these assessments had not always fully considered the principles of the MCA and the professional code of conduct, which would have ensured the least restrictive options available were followed. We saw for example one person who lacked capacity was receiving their medication covertly. Whilst we saw evidence to confirm the registered manager had now sought the involvement of a GP to provide a decision about this, we found this decision making had not included the involvement of others, such as independent mental capacity advocates to ensure it was in this person's best interests to receive their medicines covertly. We spoke with the registered manager about this who said, "I have been in such a hurry, I must have overlooked this consideration." We also saw that an application for an authorisation for this person to have their liberty restricted, which made no mention of use of covert medication included in this.

We found evidence of assessments, in two people's care files who had no verbal communication, that lacked appropriate decision making for sharing their room. We were unable to find evidence the principles of the MCA had been followed in relation to this. Also, evidence implied that decisions had been made unilaterally by the service, rather than with multidisciplinary involvement to ensure their best interest were promoted.

We found that the care plans reflected significant issues for the care and support of people who did not have full mental capacity as defined by the Mental Capacity Act. This

Inadequate

Is the service effective?

could reflect the need for training amongst staff members and also explicit guidance for staff to support their working knowledge of such issues and how best to support vulnerable individuals within the home.

This is a continued breach of regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Requires improvement

Is the service caring?

Our findings

Whilst people who used the service told us, "The staff look after us and are very caring", "Staff are very friendly", "I like it here" and "We can choose when we go to bed", further sustained progress was required to ensure people's independence and personal dignity was promoted.

At our comprehensive inspection on 8 and 9 January 2015, we had concerns in relation to the lack of promotion of people's general wellbeing. The concerns identified were a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010 which relates to Regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our focused inspection on 6 and 7 July 2015 we found that the registered provider had taken action to meet the shortfalls in relation to the requirements of Regulation 10. However, further progress and evidence of sustained improvements was required to ensure compliance with this regulation. We are currently considering our regulatory response.

Following the comprehensive inspection we told the registered provider to take action to ensure suitable arrangements were in place to ensure the dignity; privacy and independence of people using the service were considered and respected. During this focused inspection we found that screening curtains had been installed in shared bedrooms, to ensure people's privacy and personal dignity were respected. The screening curtains were fitted with a safety release system in order to reduce potential harm to people. We found that a beautician, hairdresser and chiropodist now attended the service on a regular basis to enable people's personal preferences and needs to be promoted.

People who used the service told us they had been consulted about improvements in the home, to enable their suggestions and ideas to be obtained and acted on. They told us about a recent event that had been held to enable them to participate and give support for veterans of the armed services. We saw a dignity board on display, providing information and advice together with details of staff responsible for promoting this aspect of the service. We saw information on display providing feedback for people in the form of a 'You said, we did' document that detailed improvements that had been made, including development of the menus and visits out that were planned.

We saw evidence in people's care files of consent that had been obtained where possible and involvement in decisions about their support arrangements. We were told about trips out to Cleethorpes and a local zoo that were planned. We observed staff playing board games with people and providing individual support and reassurance to people. We also saw group activities using large print playing cards which enable people to take part and feel included. The registered manager told us they would like to develop the activity provision further and were actively recruiting for an activities co-ordinator, but told us that so far this had proved unsuccessful. During our focused inspection we observed there were limited opportunities provided for people who were nursed in bed to have their social needs and wellbeing promoted. We also saw limited staff interaction with people who used the service, with one person frequently seeking communication and involvement with us as this need was not being met by staff.

We found that a person who used a wheel chair had difficulties with accessing the lounge, due to a fire door opening in the opposite direction, which meant their independence and personal dignity was compromised.

Inadequate

Is the service responsive?

Our findings

People who used the service told us they had, "No complaints" and were happy with the service they received. However, a visiting district nurse told us they had become involved, due to a lack of awareness by staff of the support that was required for a person who had recently been discharged from hospital.

At our comprehensive inspection on 8 and 9 January 2015, we found people's needs were not fully assessed and care was not planned and documented thoroughly. This meant there were risks that important care could be missed or people may not receive all the care and support they required. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which relates to Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our focused inspection on 6 and 7 July 2015 we found that the registered provider had not taken appropriate action to meet the shortfalls in relation to the care and welfare of people who used the service. This meant that the registered provider continued to be in breach of this regulation. We are currently considering our regulatory response.

Following the comprehensive inspection we told the registered provider to take action regarding the development of care plans to ensure people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. At our focused inspection we found a stroke care plan was in place for one person who used the service, which stated, 'I would like staff to monitor me in case of deterioration in my physical condition'. We saw however there was no indication as to how this monitoring should be undertaken and that no monitoring records were being completed. The care plan failed to describe how the deterioration would affect the person's physical appearance or what signs to look out which would indicate a stroke had occurred.

We spoke with a district nurse who was visiting the home to support the staff. The district nurse told us, "The staff have worked with us and [Name] has been comfortable here." However, they also said that there was a lack of staff awareness about the specialist administration of palliative care medicines.

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our comprehensive inspection on 8 and 9 January 2015 we found there were limited opportunities to enable people be involved in meaningful activities. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which relates to regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our focused inspection on 6 and 7 July 2015 we found that the registered provider had taken action to meet the shortfalls in relation to the requirements of Regulation 10. However, more progress and evidence of sustained improvements was required to ensure compliance with this regulation. We are currently considering our regulatory response.

At our focused inspection we observed evidence of consultation with people to ensure their participation in decisions about their lives. However, we were unable to see evidence of a regular programme of events or opportunities to enable people to have one to one time with staff and ensure that their independence and wellbeing was promoted. The registered manager told us they had advertised for a person to undertake this role, but that so far their attempts had proved to be unsuccessful.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are currently considering our regulatory response.

Inadequate

Is the service well-led?

Our findings

Staff told us, "Things have changed for the better" and reported they felt well supported by the other staff and received training and received supervision to help them to carry out their roles. However, we found continued multiple breaches of regulations which meant the service was not well led.

At our comprehensive inspection on 8 and 9 January 2015 we found there was no registered manager for the service, which is a breach of the registered provider's conditions of registration. We also found that incidents had not always been reported to the Care Quality Commission as required. This was a breach of regulation 18 of the Care Quality Commission [Registration] Regulations 2009 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010.

Following the comprehensive inspection we told the registered provider to ensure all episodes of challenging and aggressive behaviour were reported and investigated to ensure lessons could be learnt and action taken to reduce or prevent future incidents taking place. During this focused inspection we found evidence to confirm that incidents were reported to the local authority safeguarding team which enabled them to carry out their roles effectively. We have subsequently received notifications of the incidents as required under Regulation 18 of the Registration Regulations 2009; Notification of other incidents.

At our focused inspection 6 and 7 July 2015 we found the manager of the service had become registered with the Care Quality Commission on 13 May 2015. We found the registered manager was aware of their responsibilities and was now submitting notifications of significant events to enable the quality of the care to be monitored.

At our comprehensive inspection on 8 and 9 January 2015 we found that the registered provider had failed to ensure effective systems were in place to assess and monitor the level of service provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At our focused inspection on 6 and 7 July 2015 we found that the registered provider had not taken appropriate action to meet the shortfalls in relation to the requirements of Regulation 17. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response.

During the comprehensive inspection we noted a system had been introduced to enable the quality and safety of the service to be monitored but saw this had failed to identify shortfalls and recognise issues that placed people who used the service at risk of potential harm. At our focused inspection we found numerous concerns that had not been highlighted by the registered provider's quality assurance system. We are currently considering our regulatory response.

We looked at six care plans and found they were not sufficiently detailed or robust and lacked the level of detail required to support people effectively. Risk management plans failed to include adequate guidance for staff or pre-cursors to people behaviours and lacked insight into people's mental health conditions. We found evidence that numerous 'care file audits' had been undertaken which had failed to highlight these issues. The registered manager told us, "The audits have checked that certain things are in place but not the quality" and went on to say, "We will improve the audits and I will make sure they [the audits] become more effective."

We found evidence that a member of care staff had written care plans for specific needs such as, 'mental health issues'. The care plan focused on the management of the person's schizophrenia. However, when we checked the registered provider's training records we noted that schizophrenia was not covered in any of the training completed by the member of staff which meant that the person who wrote the care plan did not have the knowledge and skills to do so. The care plan lacked insight into the person's condition and what action staff should take to support the person. A stroke care plan had been developed for one person who used the service, the plan failed to provide guidance with regards to what indications may be presented when the person was potentially likely to suffer a further stroke and had been written by a person who had not received stroke awareness training. This demonstrated that the 'care file audits' completed were ineffective and had failed to highlight these examples of inadequate care planning.

During the comprehensive inspection we told the registered provider to ensure staff had completed pressure area training and understood the importance of ensuring

Is the service well-led?

people who were at risk of pressure damage were repositioned at designated intervals. During this focused inspection we checked the 'daily repositioning and skin inspection chart' for two people who used the service. We found numerous occasions were the two hourly repositioning had not been achieved and the 'from' and 'to' time had not been recorded which meant it was unclear if the person had been repositioned. However, each 'daily repositioning and skin inspection chart' had been signed to show it had been reviewed and completed by a senior member of staff. This showed that monitoring was ineffective and action was not taken to ensure people were repositioned correctly, which put them at a high risk of developing pressure sores.

A 'manager's monthly quality assurance assessment' had been introduced since the comprehensive inspection on 8 and 9 January 2015; part of the assessment covered the documentation required to be in staff files. When we looked at the staff files we could find no evidence of the personal identification numbers (PINs) for the registered nurses. We asked the registered manager who told us that if the pin number was not in the staff file then the file was not up to date. The registered manager then checked the nurses' registration status on the Nursing and Midwifery Council [NMC] website. This demonstrated that the 'manager's monthly quality assurance assessment' was not effective and could have led to nursing staff potentially providing care when their registration had lapsed.

There was evidence that the registered provider was visiting on a regular basis and meeting with people who used the service and staff. We saw the number of audits used to monitor the service had been increased to cover various aspects of the home, together with actions required to address shortfalls that were noted. The 'manager's monthly quality assurance assessment' was also used to ensure staff had completed relevant training that would enable them to care for people effectively. During the comprehensive inspection we highlighted that only six members of staff had completed 'mental health matters' training. At this focused inspection we saw that seven members of staff had still not completed this training, even though the service is registered to provide care to people with mental health conditions. When we reviewed the training certificates we saw that the training did not cover certain mental health conditions that people who used the service were living with. This meant that staff did not have the required knowledge and skills to care for people who used the service and the 'manager's monthly quality assurance assessment' had been ineffective in highlighting this.

This failure to appropriately oversee the service has been on-going since the inspection that took place on 21 August 2014 and demonstrates the registered provider's consistent inability to meet the Health and Social Care Act 2008 regulations.

This is a continued breach of regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010, which relates to Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are currently considering our regulatory response.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks of receiving care or treatment that was inappropriate or unsafe. This was because assessments and effective care planning for people had failed to take account or give insight into their needs.

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not always safeguarded from harm because signs of potential abuse were not recognised or appropriate action had not been taken to ensure people received safe care and treatment.

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The building had not been appropriately maintained which meant people were supported in unsafe or unsuitable premises.

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient numbers of suitably qualified, skilled and experienced staff available at all times to meet people's needs safely.

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not always provided with appropriate support and professional development to enable them to carry out their roles and ensure the needs of people who used the service were met.

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Capacity assessments for people had not always fully considered the principles of the Mental Capacity Act and the professional code of conduct, to ensure the least restrictive options available were followed.

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always provided with appropriate meaningful opportunities to enable their independence and wellbeing to be promoted.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had failed have effective oversight of the service, because the quality assurance systems had failed to identify shortfalls which meant opportunities to develop the service were missed.

The enforcement action we took:
We are currently considering our regulatory response to the continued breaches within this report and will report of them when the action is complete.