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Bearnett 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected this service on 2 May 2016 and it was an unannounced inspection. Our last comprehensive inspection took place in October 2015. And a focused inspection took place 5 January 2016. We found that actions were required to improve the care of people. At this inspection we found insufficient improvements had been made which included the way people's risks and medicines were managed, how people were protected from potential abuse and report concerns externally. Reasonable steps to improvements were also needed to ensure people were supported with consent and ensuring effective systems were in place to identify when improvements within the service were required. The provider sent us a report in December 2015 explaining the actions they would take to improve. At this inspection, we found that the necessary improvements had not been made.

The service was registered to provide accommodation for up to 29 people. At the time of our inspection 25 people were using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available on the day of our inspection.

People were not safe. Risks to people's care such as falls prevention were not managed appropriately. When risks to people had been identified by the provider action had not been taken to mitigate their risk. There were an insufficient number of staff within the home to keep people safe. The dependency tool used to plan staffing levels was not reflective of people's needs. We could not be sure people were receiving as required medicines as prescribed as there were not safe systems in place in relation to this.

When people were unable to consent, mental capacity assessments and best interest decisions were not always completed. The provider had considered when people were being restricted unlawfully but had not assessed how people could be supported in the least restrictive way. People told us they were not always involved with reviewing their care and they would like to be. We found that people were not protected from potential abuse as concerns were not always investigated or appropriately reported.

Referrals to health professionals were not made in a timely manner and there was a reliance on the district nurse team to make these referrals. When assessments had been completed by professionals the service did not ensure that their recommendations were implemented. We found that people's nutritional needs were not monitored and recorded accurately. Staff told us they received training however this did not help them to support people. People did not always have the opportunity to make choices and staff had little time to spend and interact with people.

The systems that were in place to improve the quality of the service were not effective. The information from

audits was not used to bring about improvements or make changes to the service. Opinions were sought from relatives however when concerns were identified no action was taken to address them. The systems in place to ensure staffs suitability to work in a caring environment were not always completed by the provider.

People enjoyed the food and were happy with the staff. People knew how to complain and staff felt they had the opportunity to raise their concerns.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

When people were at risk there were no management plans to identify and manage these risks. When risks had been identified appropriate action had not been taken to reduce these risks. There were not enough staff available to keep people safe. The provider did not take reasonable steps to protect people from potential abuse. People's needs in relation to as required medicines were not being met. The provider had not always checked the suitability of staff working within the home. Medicines were stored and administered in a safe way.

Is the service effective?

Inadequate

The service was not effective.
The principles of the Mental Capacity Act 2005 were not followed. Some people who needed them did not have capacity assessments in place. The reason decisions were made for people were not demonstrated to be in there best interest. Staff did not take responsibility to refer people for specialist advice and there was reliance on the district nurses to complete this. Staff told us the training and induction they received did not help them support people. People's nutritional needs were not monitored and managed appropriately. People enjoyed the food and were offered choices.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always treated in a dignified way and staff did not always have time to spend time with people. People were happy with the care they received. People felt their privacy was upheld. When people had capacity they felt they could make decisions about how they spent their day.

Is the service responsive?

Requires Improvement

The service was not always responsive.
When people had raised concerns or complaints there were no evidence that these had been recorded or responded to. People were not always involved with reviewing their care. Referrals to

health professionals were not made by the provider when needed, or in a timely manner.
People told us staff knew them well and they had the opportunity to participate in activities they enjoyed.

Is the service well-led?

Inadequate

The service is not well led.
We do not have confidence in the provider. Some quality monitoring was completed however this information was not used to identify and bring about improvements. When action was required to reduce further risks this was not taken. Systems to review and monitor care were not effective. Staff told us they were given the opportunity to raise concerns.

Bearnett 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 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 visit took place on the 3 May 2016 and was unannounced. The inspection was carried out by two inspectors. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. We also spoke with the local authority who provided us with their current monitoring information. We used this information to formulate our inspection plan.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we offered the provider the opportunity to share information they felt relevant with us.

We spoke with three people who used the service, one relative, three members of care staff and the activity coordinator. We spoke with the manager of care and the deputy manager and we also spoke with a visiting health professional. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for six people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection in October 2015 we found there was a breach of Regulation 12 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At that time the provider did not have suitable arrangements in place to manage risks to people. People were not safe as medicines were not managed stored or administered in a safe way. A warning notice was served in relation to Regulation 12 management of medicine and management of risks. A focused inspection was carried out in January 2016 and we found the provider had made the necessary improvements. At our last comprehensive inspection in October 2015 we also found the provider had not taken reasonable steps to report and investigate potential abuse to people. At this inspection we found the provider had not made the required improvements to comply with the Act.

Risks to people were not managed in a safe way. For example, we saw one person had fallen six times over a 21 day period. It was recorded that all of the falls had occurred in the person's bedroom. We saw there were two risk assessments in place for this person. One risk assessment identified that the person was at 'low risk' of falls and a further risk assessment identified that they were at 'medium risk' of falls. Neither of the risk assessments included an assessment of the person's risk of falls associated with their bedroom. We did not see that any action had been recorded or taken on how this risk could be managed or reduced. This meant the person was at risk of further falls and causing harm to themselves because there were no systems in place to manage these falls or to look at how to keep the person safe. We looked at the provider's policy for the management of falls. This stated if a person sustained two falls a referral would be made to the falls prevention team and a referral had not been made. We spoke with the management team who confirmed this had not been completed. This meant the provider was not following their own procedure around the management of falls.

We looked at records for another person. It was documented they had fallen five times throughout February and March 2016. This person had previously been referred to the falls prevention team in 2015. We saw that the falls team had provided a report to the provider which included preventative recommendations to reduce the risk of further falls. These recommendations included, observing the person walking around the home, particularly their access to the stairs and encouraging them to lift their chin to improve their view. During the morning of our inspection we observed the person walking independently. We did not see staff observing this person or encouraging them to lift their chin as recommended. The person was observed walking around the stair well. There was no environmental risk assessment in place to mitigate the risk of the open staircase. We spoke with staff about this. One member of staff told us they were unsure of this person's risk. They went on to say, "We get [person] washed and dressed as early as possible so they can go into the communal area, as there is always someone in there, that is how we reduce the risks for [person]". We also saw this person had previously banged their head on the celling of the under stair. The falls prevention team report stated that foam padding should be applied to the area to prevent injury. At our previous inspections we saw this foam padding was in situ. At this inspection the foam padding had been removed. One member of staff told us this had been removed because, "The provider did not like the look of it". We looked at records for this person. We saw that two accident forms had been completed in March 2016. On both occasions it was documented an injury had occurred to the person's head, which had

resulted from them banging their head on the under stair. This meant people were at risk of harm as appropriate action had not been taken and maintained when risks were identified.

Some people used assisted technology such as sensor mats to keep them safe. The management team told us that five people within the service used this equipment. We looked at records for these people but we did not see any risks assessments or care plans stating how and when the sensors should be used. We observed one person sitting in the communal reception area of the home. We observed there was a sensor mat placed next to them on the floor. During the course of the day we became concerned that the mat was inactive. We spoke with a staff member about this. They confirmed this was because the sensor mat had not been switched on. They also told us the person did not need this equipment while in the communal areas. The positioning of the sensor mat could have presented a trip hazard for other people who were walking past and demonstrated that staff were not aware when they should be used.

We observed that a person was verbally challenging to another person. Staff had to intervene in this situation to prevent this from becoming a physical altercation. We observed that four members of staff went over to the person to intervene. The staff then called the deputy manager for assistance. The deputy manager offered assistance and verbally diffused the situation. Staff told us that this person was often both verbally and physically challenging to other people. We looked at records for this person. We did not see any risks assessments or documentation to highlight the risk or information on how this should be managed. We looked at records for two other people. The records stated that these people could display both verbal and physical behaviours that may put others at risk. We did not see any risk assessments or management plans to support people with these behaviours.

This is a continuing breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw procedures were displayed to guide staff on how to report concerns or potential abuse to the local authority. However we saw that these procedures were not always followed. For example, one person had been admitted to the service in April 2016. A body map had been completed for this person. The body map stated that the person had six separate bruises. There was no further documentation to indicate if the person was admitted with these bruises or if they had occurred within the home. A member of staff confirmed they were unsure how and when these bruises had occurred. During handover we heard staff report a large fading green bruise about another person. Staff said they thought this was associated to a previous fall the person had sustained. We looked at records for this person. It was reported that this person had an unwitnessed fall in April 2016. There was no documentation identifying that this bruise to the shoulder had occurred. The provider had not investigated the cause of either bruising or reported it to the local authority safeguarding team as required. This meant we could not be sure people were protected from potential abuse.

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

There were not always enough staff to ensure people were safe. One person told us, "Some days it's better than others, I have to wait sometimes". A member of staff said, "We are well staffed this morning, we don't usually have this many as we are short a lot". A health professional we spoke with raised concerns about the lack of staff that were available within the service. They said, "There are not always enough staff available". We observed for periods throughout the day people were left unsupervised in communal areas. Some of the people left unsupervised had been identified as being at risk of falling. Without the supervision from staff this meant if there was an incident or emergency staff would not be available to respond to this. We

observed other people did not always have access to call bells; some of the people unsupervised in the communal areas did not have the capacity to seek support from staff if needed. We did not see any risk assessments that had considered this for people. We spoke with the management team about this. They told us a dependency tool was used to work out staffing levels based on individuals dependency needs. We looked at the records for this. We saw the needs documented on the dependency tool did not always match the assessed needs of people. For example, one person was identified as low dependency. However, the information recorded had not considered the recent changes to this person mobility and the amount of falls they had sustained. This meant we could not be sure the dependency tool gave an accurate account of the amount of staff required.

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

Some people living in the home received medicines on an 'as required basis'. We saw there were protocols in place to help staff identify when a person may need these medicines and the frequency people could receive them safely. However the information on the protocols did not always match the information on the medicines administration records (MAR). For example, one person was prescribed medicines for agitation. The protocol written by the home stated 'take half a tablet twice daily if absolutely necessary for agitation'. The MAR record stated 'take half a tablet only at night if absolutely necessary for agitation'. The MAR and staff confirmed that this medicine had been administered daily from 25 April to 2 May 2016. We looked at records for this person during this period and saw that there was no documentation that the person had been agitated and required this medicine. Staff were unsure if the person would have needed this medicine. Staff confirmed they had not contacted the person's GP to review this medicine. By administering these medicines on a regular basis there was a risk the person was receiving these medicines when they did not require them. Another person was prescribed medicines for agitation. We saw there was an 'as required' protocol in place for this person. This stated the person should receive 'half a tablet at night if nothing else calms them down'. The MAR stated that the person should 'receive this each evening'. We spoke with staff about this who could not confirm if this was regular or as required medicines. This meant that safe systems were not in place to ensure people's needs in relation to occasional medicines were being met.

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

Medicines were administered to people in a safe way and staff spent time with people ensuring they had taken them. We observed staff take the MAR and a photograph of the person to the person before administering the medicines to ensure it was the correct person. Medicines were stored securely and at the correct temperature to preserve their condition.

We looked at three recruitment files. We saw evidence and staff confirmed they had pre-employment checks before they started working within the home. However, for one person we saw there were significant gaps in their job history, but there was no evidence that the reason for this had been looked into or discussed with the person at interview. We saw staff were asked to complete a declaration about previous criminal convictions. We saw that two of the three people had completed this. Therefore we could not be sure the provider had checked all staffs suitability to work within the home.

Inadequate

Is the service effective?

Our findings

At our last comprehensive inspection in October 2015 we found there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At that time the provider was not working within the principles of The Mental Capacity Act 2005. At this inspection we found the provider had not made the necessary improvements to comply with the Act.

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

We looked to see if the provider was working within the principles of MCA. Staff confirmed that some people living in the home lacked the capacity to make certain decisions for themselves. When people were unable to consent, mental capacity assessments and best interest decisions were not always completed. Staff confirmed one person lacked capacity, we did not see and staff could not show us that a mental capacity assessment had been completed. When capacity assessments had been completed there was no recognition of fluctuating capacity or no evidence to describe what choices people could make for themselves. The capacity assessments did not show how decisions had been reached. For example, we saw that one person used bed rails to keep them safe. There was no capacity assessment in place for this decision or a consent form to show the person had agreed to this. Staff confirmed this person would not be able to consent to this as they lacked the capacity to do so. We did not see and staff confirmed that this decision had not been discussed and recorded to be in their best interest. For one person we saw records for use of restraint. These records showed that the person was being restrained using a reclining chair. There was a risk assessment in place for this. This was in relation to entrapment if a fire occurred. The care plan stated the chair was 'reclined slightly to discourage [person] from trying to stand unaided'. We did not see any evidence that the person had consented to this. We spoke with staff who confirmed this person lacked capacity to make this decision. There was no capacity assessment for this person or a best interest decision in relation to this. Staff confirmed this had not been completed. We did not see any best interest decisions demonstrated for other people who lacked capacity living in the home. Staff we spoke with did not demonstrate an understanding of the process to follow when people lacked capacity, even though they told us they had received training. One member of staff told us, "It's about keeping people safe I think and talking with their relatives when they come". This meant that people's rights under MCA were not addressed.

This is a continuing breach of Regulation 11 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

We spoke with the management team who confirmed 19 applications for DoLS had been made to the local

authority. They confirmed that two assessments had been completed and approvals had been received. Records showed us that applications for DoLS referrals had been completed before mental capacity assessments. This demonstrated a lack of understanding by the provider because people with capacity did not need to be referred. We saw one person tried to leave the building during the afternoon. We saw three staff approach this person and manage this in a different way. This meant there was not a consistent approach for this person. We did not see any evidence that risk assessments were completed to ensure people were being supported in the least restrictive way while approvals were being considered. The management confirmed these were not in place.

Staff did not take responsibility to refer people for specialist advice. We saw there was a reliance on the district nurse team to offer support with this. For example, one person who was losing weight had been referred to a dietician by the district nurse team. The district nurse team confirmed they had made this referral, they told us they felt there was a reliance on them to make referrals. We spoke with the management team about this and why the provider had not made the referral. They said, "The district nurse team picked up on this weight loss not us, this was because they were doing a dietary assessment score and not us, we didn't know they had lost weight". This demonstrated referrals to health professionals were not made by the provider when needed.

There were daily arrangements in place to keep staff informed about people's needs. We observed a handover between staff. We heard staff being told that recommendations had been received to improve the food intake for a person. This was following an assessment that had been completed for weight loss. It was highlighted that the person should be offered frequent snacks to improve their calorie intake. At lunchtime this person was offered support to eat their meal. The person refused their food. The meal was replaced with a supplement, which during the course of the afternoon they mixed with their drink and then spilt. This was taken away and not replaced. During the afternoon tea round we observed this person was offered one biscuit which the person ate. We observed throughout the day drinks were left with this person and no encouragement to drink them was offered. We checked the records for this person. There was a fluid balance chart in place. It was documented that the person had finished all the drinks that they had been offered during the morning and the meal supplement. We saw it was documented in the dietician's assessment that 'drinks had been recorded as taken that I noticed were only half completed on the table next to [person]'. This demonstrated that people's nutritional needs were not managed and monitored accurately despite specific advice from a health care professional.

Staff told us they received training however they did not feel it helped them support people who used the service. For example, one member of staff told us they had received moving and handling training. They explained that after the training they did not feel proficient in this area. Another staff member said, "We have more training now, its better but still not good, I think it's as we watched videos'". When staff started working within the service they told us they did not have an induction or the opportunity to shadow other staff. We spoke with the management team about this they told us that new starters received a comprehensive induction but did not provide any evidence to support this. This meant staff did not always receive support and training that helped them to meet people's individual needs.

People we spoke with told us they enjoyed the food. One person said, "The food is beautiful". We saw that people were offered a choice at mealtimes. One person did not like the options that were available so requested an alternative meal which was provided for them.

Requires Improvement

Is the service caring?

Our findings

People were not always treated in a dignified way. At lunchtime we observed that some people had clothes protectors put on. People were not asked if they would like to wear these and some people had them put on without permission or warning from staff members. Staff did not always have the time to support people. For example, we observed one person sitting in the communal area needed support with their drink. Various staff walked past this person and did not offer any support. We saw that most interactions from staff occurred when a task was taking place and the staff had little time to talk to and interact with people.

People and relatives told us they were happy with the staff. One person said, "I have a laugh and a joke with the staff". A relative told us, "The girls here are great. We've been very happy with the care". We saw people were relaxed with staff. People told us staff were welcoming and they could visit anytime. One person said, "My [relatives] come whenever they choose, anytime of the day or night. The staff bring me back to my room as they know we like sometime alone so we can chat". Another person told us, "I bring my friends back sometimes and the staff always put the kettle on". This demonstrated that visitors were welcomed by staff.

People told us there privacy was promoted. One person said, "They always knock on my door and then I shout them in when I am ready". Another person had requested they locked their bedroom door when they were in there. We saw the door was locked and the person confirmed this to us. Staff gave us examples of how they promoted people's privacy. One staff member said, "When people are in their rooms I always knock the door and ask them if it's ok for me to come in".

People told us they were able to make decisions about their day. One person said, "I prefer to eat in my room. That's fine, they don't argue about that". Another person told us, "I like the peace and quiet of my room I know I can go downstairs if I want". We saw that staff respected people's wishes and supported them to spend time where they preferred.

Requires Improvement

Is the service responsive?

Our findings

People told us if they had any complaints or concerns they would be happy to raise them. One person said, "No complaints I'm happy here, I would speak to staff if I wasn't". The provider had a complaints policy and system in place to manage complaints. The management team told us they had received no recent complaints. However prior to the inspection we received information that complaints had been made and these had not been looked into. We did not see any evidence of these complaints. This meant we could not be sure all complaints had been responded to.

We looked at records for a person; this showed us that a person had sustained an injury from on unobserved fall. A member of staff reported that the person had a skin tear. The following day the person was seen by a member of the district nurse team who reported the person's 'left wrist was bruised and swollen and there was heavy bruising to the right thumb'. On the advice of the district nurse team this person was taken to hospital. The person was diagnosed with two fractures. This demonstrated that referrals to health professionals were not made by the provider when needed, or in a timely manner.

People told us staff knew about their preferences and support was provided in the way they wanted. One person said, "I always get up and have my breakfast before my shower, they know that's my routine". We observed a staff member talking to a person about their family and explaining what day they would be visiting. However we found this to be inconsistent.
Some people told us they were not involved with reviewing their care. One person said, "The staff do that, I have a file that the staff write things in but I have never read it, I would like to know what they put in it". The care files we looked at did not show how people were involved with planning and reviewing their care.

People told us they enjoyed the activities. One person said, "There's much more going on now". Another person told us, "I'm not in my room as much now, as there's plenty more to do". We saw there was an activity coordinator in post and activities were taking place. There was information displayed in the communal area about activities that were taking place within the home in the coming weeks. This meant people had the opportunity to participate in activities they enjoyed.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection in October 2015 we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At that time the provider did not have suitable systems in place to ensure areas for improvement were identified. At this inspection we found the provider had not made the necessary improvements to comply with this breach of regulations.

We have inspected this location on three separate occasions in a seven month timeframe. At this inspection we found that despite concerns raised from our previous inspections and a meeting with the provider few improvements to the provision of the service had been made or sustained. This demonstrated the management systems that were in place were weak and inconsistent. We have also listened to concerns raised by health care professionals who work closely with the service. Following this inspection we have concluded that we do not have confidence in the provider to make the necessary improvements required for the care and safety of people living at Bearnett House.

We could not be assured that the provider understood the responsibilities of their registration with us. At the inspection we found there were safeguarding concerns that had not been identified by the provider. These concerns we around the alleged abuse of people who used the service, as the management systems that were in place were not identifying these as concerns, the provider had failed to notify us of these event.

There were some systems in place to monitor the quality of the service. However we did not see this information had been used to bring about change. For example, we saw the provider was monitoring falls. Records showed there was a tally chart that stated how many falls had occurred within the home. A graph had also been produced with this information. We did not see how this information had been used to bring about changes. For example, in March 2016 13 falls had been recorded as unwitnessed. There was no information stating if this was for the same person or how any risks had been reduced. This demonstrated when change were required no action was taken to improve.

We saw from records that incidents and accidents were reported. When incidents had occurred we did not see action was taken to mitigate further risks. For example, we saw three incident and accident forms that stated an injury had occurred to a person as a result of an accident caused by staff. One injury occurred when it was reported that a staff member turned around and knocked a person over. It was reported this person 'knocked their back on the printer before falling to the ground'. It was further documented the person had a 'large very purple bruise/graze on the left side of their back'. We did not see a risk assessment had been completed in respect of this. We spoke with the management team who confirmed no risk assessment had been completed or action taken to reduce this risk in the future. This demonstrated that when action was needed to reduce future risks this was not taken.

The provider had introduced a health and safety audit. This looked at areas including, mattress audits and portable appliance testing (PAT) to ensure the electrical items in use were safe to use. The audit stated on 10 April 2016 that PAT testing needed to be completed as soon as possible. We did not see any evidence this had been completed. We spoke with the management team about this who showed us the records, this

confirmed that the last PAT testing was completed in January 2015. And the action referred to on 10 April 2016 had not been completed. We also saw records for a mattress audit. We saw actions had been set to bring about improvements. For example, we saw for some people plastic protectors need to be ordered and for other mattresses areas needed to be cleaned. We did not see any evidence this had been completed. We spoke with the management team. They told us, "Yes, I think this would have been done". They did not provide any evidence to confirm this. This demonstrated when actions had been identified to bring about improvements; they were not always completed as needed.

Systems that were in place to review and monitor care were not always effective. We saw that care files had been reviewed; however there was no evidence that changes to people's care had been made. For example, one person had received an injury that had resulted in their arm being encased in a plaster. There was no review to this person's care following this and no short term plan in place to ensure the persons altered needs were met while the functionality of the arm was reduced. For another person we saw their mobility had decreased following a hospital admission. It was recorded they had 'very poor mobility'. However, the person had a personal emergency evacuation plan in place that stated they would 'walk to the fire escape'. This had not been reviewed or update following the changes to the person's mobility and could lead to confusion in an emergency situation.

We saw that a survey had been completed to capture the views of relative and friends of people who used the service. This information was displayed in a graph in the communal area. Where areas of improvement had been identified we did not see any action had been taken to make improvements. For example, one relative had stated that they were unhappy with how complaints had been dealt with and had scored this as 'poor'. We could not see and the management team confirmed that no action had been taken to improve this.

This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff told us and the management team confirmed that supervisions and team meetings were taking place. One member of staff said, "We have a meeting with either the deputy manager or the care manager now. Its better we have the chance to say things if we are unhappy". As the provider had not made the necessary improvements and people were not receiving good care we could not see how staff supervision had been used to bring about changes and improvements to the service. This demonstrated that the supervision staff received was ineffective.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 were not followed. Some people who needed them did not have capacity assessments in place. The reason decisions were made for people were not demonstrated to be in there best interest

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not take reasonable steps to protect people from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available to keep people safe.

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 12 HSCA RA Regulations 2014 Safe care and treatment When people were at risk there were no management plans to identify and manage these risks. When risks had been identified appropriate action had not been taken to reduce these risks. People's needs in relation to as required medicines were not met.

The enforcement action we took:

We issued an NOD to restrict admissions into the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have suitable systems in place to ensure areas for improvement were identified. When action was needed to reduce further risks this was not taken. We do not have confidence in the provider.

The enforcement action we took:

We issued a NOP with positive condition around the management of falls within the home.