Prime Life Limited

Phoenix Park Care Village

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

Phoenix Park Care Village is a purpose build home situated on the outskirts of Scunthorpe. It is registered to provide accommodation for people who require nursing or personal care for a maximum of 111 people.

The service is separated into two units Hilltop and Overfields. Hilltop offers 77 single ensuite rooms for older people some of whom may be living with dementia, complex medical conditions and behaviours that may challenge the service and others. Overfields provides 34 single ensuite rooms for younger adults with complex needs and mental health conditions. At the time of our inspection there were 12 vacancies within the service. The service offers a number of communal lounges, conservatory, kitchens, a mixture of dining and bistro areas, games rooms, hairdressing and beauty salon, landscaped gardens and outdoor seating areas.

At the commencement of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission [CQC] 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. By the third day of our inspection the registered provider had decided it would be prudent to move the registered manager to run another registered service.

We carried out an unannounced comprehensive inspection of this service on 17, 25 & 28 September 2015. During the inspection we found the registered provider was in breach of Regulations 9, 10, 11, 12, 13, 17 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 providing person centred care, treating people with dignity and respect, obtaining appropriate consent and following the principles of the Mental Capacity Act 2005, providing safe care and treatment, safeguarding people from abuse and improper treatment, utilising effective systems to monitor and improve the quality of service provision and ensuring staff had the skills, abilities and support to meet people's needs.

The registered provider gave us their assurance that further admissions to the service would not take place until we were satisfied appropriate arrangements were in place to ensure people's health, safety and welfare was protected and the registered provider had achieved compliance with all of the relevant regulations.

We undertook this focused inspection on 27 & 28 January and 12 February 2016 to check whether the registered provider 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 Phoenix Park Care Village on our website at www.cqc.org.uk.

This inspection was completed because the registered provider's nominated individual told us, 'all of our internal governance measures have evidenced a positive service to the clients, and we are confident that a return inspection will show significant improvement to the ratings previously offered' and 'I am confident

that the service being offered is both safe and effective, and is able to evidence a sustained level of good practice and outcomes for clients'. The nominated individual suggested a phased lift to the voluntary suspension of new admissions so we inspected to ascertain whether compliance had been achieved.

At our comprehensive inspection of the service in September 2015 we found that people did not always receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 9. People's care plans were not appropriate, did not reflect people's current level of need and assessments of people's need were not completed when their needs changed or when they were discharged from hospital.

At our comprehensive inspection of the service in September 2015 we found that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 10. Staff did not always treat people dignity and respect and inappropriate language was used in people's care plans.

At our comprehensive inspection of the service in September 2015 we found that the service had failed to ensure consent had been gained from people or through a best interest forum before care, treatment and support was provided. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 11. Consent was not always gained before care and treatment was provided and the principles of the Mental Capacity Act 2005 (MCA) were not followed when people lacked the capacity to make informed decisions themselves.

We also found that the requirements around ensuring the appropriate legal framework was in place when someone was deprived of their liberty was not in place. The registered provider had failed to take sufficient action to meet the requirements of regulation 13 (5) of the Health and Social Care Act 2008, (Regulated Activities) regulations.

At our comprehensive inspection of the service in September 2015 we found that people did not always receive safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 12. People did not receive their medicines as prescribed, instructions to staff regarding when medicines to reduce people's anxieties should be used were inadequate and contained no insight into people's behaviours. Care plans did not contain appropriate guidance to enable staff to manage people's behaviours that challenged the service and others. Infection control practices did not reflect current guidance and staff's actions increased the chance of spreading infections throughout the service.

At our comprehensive inspection of the service in September 2015 we found people were not protected from abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 13. Restraint and physical interventions were used in a dis-proportionate way in response to the risk of harm posed to people who used the service.

At our comprehensive inspection of the service in September 2015 we found that the registered provider had failed to operate good governance systems in the service. This was a breach of Regulation 17 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 17. Quality assurance systems failed to highlight shortfalls in relation to substandard infection control practices, failures to implement professional advice and guidance, ineffective and inaccurate care plans and the lack of concordance with the MCA.

At our comprehensive inspection of the service in September 2015 we found that people were not always supported by adequate numbers of suitably trained and experienced staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 18. When staff were recruited appropriate checks and monitoring did not always take place and some staff we spoke with raised concerns over staffing levels.

During this focused inspection we found that the registered provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, fit and proper persons employed. Recruitment practices were not established and operated effectively. You can see what action we told the registered providers to take at the back of the full version of the 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. People were not protected from abuse and avoidable harm. Care plans did not provide adequate guidance or relevant examples to enable staff to manage people's behaviours that challenged the service.

Appropriate decisions had not been made about the use of physical interventions and restraint within the service. Internal policies regarding the use of physical interventions and restraint were not followed.

The registered provider failed to ensure staff adhered to all of the conditions regarding their professional registration.

People did not receive their medicines as prescribed. Detailed guidance was not available for staff to follow when administering medication on an 'as required' basis.

Hygiene standards were not adequately maintained and staff failed to take appropriate action to ensure people were protected from the risks associated with infection control.

Is the service effective?

Inadequate

The service was not effective. The principles of the Mental Capacity Act had not been followed and decisions made on people's behalf were not carried out within the framework of a best interest forum.

Decisions regarding the use of physical interventions and restraint were not carried out within the framework of a best interest forum.

When people's needs changed and developed relevant professionals were not contacted in a timely way. When professionals were contacted their advice and guidance was not consistently used to update people's care plans.

Care plans failed to demonstrate improvements or deteriorations in people's behaviours or health to reflect their current needs and contain relevant information to enable staff to

meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring. People's care plans contained judgemental descriptions which lacked insight into how people's mental health conditions affected them.

People's dignity was not always protected and staff failed to show respect for people's wishes and preferences.

Opportunities to engage with people in activities and meaningful conversations were missed.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not updated when people's needs changed. Relevant guidance was not available to enable staff to respond appropriately to people's changing behaviours.

Activities provided were not always tailored to people's individual preferences and did not meet people's social care needs.

Is the service well-led?

Inadequate

The service was not well-led. Quality assurance systems used by the registered provider were ineffective and failed to ensure action was taken to improve the service.

Care plan spot checks and care plan evaluations failed to ensure care plans contained people's current health needs and appropriate guidance was in place to enable staff to provide effective care.

Conditions regarding professional registrations were not monitored appropriately by the service.

Phoenix Park Care Village

Detailed findings

Background to this inspection

We carried out this inspection focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider was 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 ensure improvements had been made since our comprehensive inspection in September 2015.

This focused inspection took place on 27 & 28 January and 12 February; it was unannounced. On the first day of the inspection the inspection team consisted of three adult social care inspectors, an inspection manager, an enforcement inspector, two specialist infection prevention and control
Nurses from the North Lincolnshire CCG and a specialist professional advisor. On the second day of the inspection the inspection team consisted of two adult social care inspectors, an enforcement inspector and a specialist professional advisor. On the third day of the inspection the inspection team consisted of two adult social care inspectors.

Before our focused inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We were told a high number of safeguarding's investigations regarding incidents that occurred within the service were currently taking place. We reviewed all of the information we held regarding the service and the action plan sent to us by the registered provider which outlined the action they had taken regarding the shortfalls and areas of non-compliance we had identified at our comprehensive inspection.

During the inspection we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and the level of support provided to people throughout the day, including meal times.

We spoke with two people who used the service and four visiting relatives. We also spoke with the registered manager, the nominated individual, the regional director, the registered provider's chairman, the registered provider's 'Quality Matters' director, the HR director, the service's manager, four nurses, three team leaders, three senior carers, a number of care staff, domestic staff and the cook.

We looked at the care records for 15 people, including their initial assessments, care plans, reviews, risk assessments and Medication Administration Records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for 11 members of staff including information pertaining to their professional registration, staff training records, policies and procedures and records of maintenance carried out on equipment. We also completed a tour of the entire premises to check general maintenance as well as the cleanliness and infection control practices.

Inadequate

Is the service safe?

Our findings

A relative we spoke with told us, "I don't have any major concerns; I think Dad is safe here, it's a clean, happy vibrant place." Another relative said, "I was interviewed by the [local newspaper] after the last inspection. I told them I loved my husband and would not leave him somewhere I did not think he was safe" they also said, "He has been here for 15 months, the first nine were very difficult, there was a number of safeguarding [incidents] but we have all worked together and now he is in a place of harmony."

At our comprehensive inspection of the service in September 2015 we found that people did not always receive safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 12 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found that when the CQC and the local authority safeguarding team were informed of incidents that occurred within the service; an appropriate level of detail was not always included. Over a third of the staff employed at the service had not completed safeguarding of vulnerable adults training and people were being physically restrained by staff who had not completed training to do this safely. At this focused inspection we were provided with evidence to confirm all staff had completed safeguarding of vulnerable adults training and 67 staff had completed training in relation to the use of physical interventions. We were told the training focused on providing positive behaviour support, looked at behaviour triggers, early warning signs and the escalation of behaviours. At the time of our focused inspection 78 members of staff were booked onto the three day training programme which was scheduled to be completed before April 2016.

Staff who had completed the physical interventions training told us it was informative and equipped them with the practical skills they required. However, there was a distinct lack of evidence that staff had used their knowledge to update people's care plans. We found the same generic statements in a number of care plans; such as, 'staff should at times when [name] displays such behaviours ensure that they take the necessary and appropriate actions to promote their personal safety and that of others', 'staff to speak calmly to [name] providing reassurance and use diversion techniques when [name] presents any agitation and/or aggression', 'Staff are to familiarise themselves with [name] so they can anticipate their needs through reading their body language and also by reading their moods'. The care plans failed to provide appropriate guidance to staff using examples of what signs to look for that may suggest a person is becoming agitated, what action to take when signs are recognised, possible triggers to people's behaviours, talk down and de-escalation techniques that have been successful in the past, how to distract the person by using their known interests or what works to effectively reassure the person.

Since our comprehensive inspection September 2015 the CQC were notified of over 45 safeguarding

incidents that occurred within the service. It was evident that the lack of pertinent instructions for staff regarding the management of people's challenging behaviours increased the risk to people who used the service of receiving verbal or physical abuse.

This demonstrated a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach.

Staff we spoke with were aware of their responsibilities to report any abuse they witnessed or became aware of. During our discussions staff could describe the different types of abuse that may occur and what signs to look for which may indicate someone was being abused. This included, "Changes in people's behaviour, not eating, body language, flinching, unmotivated, bruises, cuts and self-harm." Staff told us they would report any concerns they had to the registered manager or regional director of the service. A member of staff told us, "In my safeguarding training we learnt about recognising abuse, reporting it and learning from incidents."

At our comprehensive inspection of the service in September 2015 we found that, although the registered manager had notified the appropriate agencies after incidents and notifiable events occurred; records held within the service contained more details about the events than what had been submitted to the CQC and the local authority safeguarding team. This meant that many of the alerts submitted had not been subjected to further investigation or had been deemed as low level incidents based on the detail and content provided. During this focused inspection we reviewed the accidents and incidents logs against the information received by the CQC.

We found that the reports we received matched the information recorded within the service but saw that we had not been notified of all incidents that had taken place. Examples of this included, one person who used the service told another person that they had been hit by a member of staff and another person told a member of staff money had been stolen from them.

The registered manager told us they used a different system following the concerns raised during our comprehensive inspection of the service in September 2015. Incident records were now stored with local authority safeguarding alerts and notifications sent to the CQC. This made it easy to see that the information provided to local authority safeguarding team and the CQC had improved and reflected the totality of the incident that had occurred. We also saw that when staff used unplanned physical interventions appropriate documentation was completed. For example, we saw incident reports, witness statements, antecedent behavioural consequence charts and body maps were used to record who was involved in the intervention, the staff, the length of time the intervention was used for and if anyone sustained any injuries. This helped to ensure the incident could be reviewed and appropriate action could be taken to prevent its reoccurrence. However, we saw these improvements did not occur after planned physical interventions had taken place.

During this focused inspection we looked at 15 people's Medication Administration Records (MARs) and saw people did not always received their medicines as prescribed because appropriate levels of stock were not in place. For example, one person had been prescribed medicines that required the dose to be increased over a period of time; the service ran out of the medicine and were unable to obtain more for over seven days. This meant the person did not receive their medicines as prescribed and had to recommence their medication at the lowest dosage.

During our observations we saw that one person who used the service was given PRN medicines to reduce their anxieties even though they had been observed to be calm and relaxed. PRN is the abbreviation used to

describe when medicines are given 'as required'. We checked the person's MARs and saw they had been prescribed the medicine up to three times a day PRN. The MARs showed the person had received PRN medicines each morning for a two week period even though their daily notes stated on numerous occasions they had not displayed any behaviours that challenged the service and were 'settled'. When we questioned why the PRN medicines had been administered we were provided with evidence confirming the person's GP had advised the service to administer PRN medicines in the morning and in the evening to help reduce the number of incidents the person had been involved in. The MARs showed that the person had not received PRN medicines in the evening, which meant that the GP's instructions had not been followed. Failing to implement advice and guidance from medical professionals increases the risk of people receiving ineffective and inappropriate care. When PRN medicines are prescribed to reduce people's levels of anxiety; failing to administer them as prescribed reduces the chances of them being effective and could lead to people continuing to display behaviours that challenge the service and increase the possibility of an incident occurring.

We checked the PRN protocols which would be used to ensure PRN medicines were given consistently and effectively. The protocols we saw lacked detail and failed to provide guidance for staff enabling them to see that some had passed a marked threshold and required PRN medicine to reduce their anxieties. There was no guidance stating the length of time between each dose, which could lead to people being over medicated and chemically restrained.

This demonstrated a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found that people were not cared for in a clean and hygienic environment. At this focused inspection we found that various pieces of mobility equipment and mattresses were stored in two people's en-suite bathrooms. This meant that the en-suite facilities could not be accessed by the person who used the service; staff told us personal care had to be provided in a communal bathroom. When we checked the communal bathroom we found five used red bags were piled on top of one another in the bathroom. Red bags are used for the transportation of soiled clothing and linen, they are designed to prevent the need to personally handle potentially contaminated items. The bags are designed to be placed into a washing machine and release the items ensuring safe infection control practices are maintained. A member of domestic staff told us that used red bags were always stored in one particular communal bathroom until they are collected at 8am and 4pm every day. This practice increased the risk to people who used the service of contracting and spreading healthcare associated infection diseases. The registered manager told us, "After you told us about the red bags; I checked with one of our domestics and asked where dirty linen was stored. They said in the bathroom, I couldn't believe it, they have done all the training, they know it's against our policies, I couldn't believe it."

At our comprehensive inspection of the service in September 2015 we found that areas of the service were not cleaned effectively, amongst other things radiator covers in dining rooms had enduring food stains and food had been pushed through to the radiator. At this focused inspection we were supported by two specialist infection prevention and control nurses form North Lincolnshire Clinical Commissioning Group. Their report highlighted both parts of the service (Hilltop and Overfields) were rated as amber and stated 'some improvement required'. They found radiators and radiator covers remained unclean with food, debris and utensils found pushed into the radiator covers, a large number of cigarette butts drying out on a radiator in one part of the service, numerous light pull cords and red emergency pull cords were unclean, trollies with mops in buckets of water left in corridors, some areas were sticky to walk on, faecal matter noted on some toilets, debris on the floors, dirty hoists, cleaning schedules were generic and made no

distinction between areas; which required reviewing and further development, cleaning wipes routinely stored on top of cisterns and episodes of poor practice by staff such as; failing to wear appropriate personal protective equipment, wash their hands when required and the inappropriate carrying of used linen.

This demonstrated a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found that people were not always supported by adequate numbers of suitably trained and experienced staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 18 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found trained and experienced staff were not deployed in suitable numbers to meet the needs of the people who used the service. During this focused inspection we saw staffing levels had been increased. A number of people who used the service received 24 hour one to one support. On the second day of the focused inspection we arrived at 5am to check that appropriate numbers of staff were in place to meet the assessed level of need and found that sufficient staff were on duty. Some of the staff we spoke with said they believed staffing levels were appropriate. However, we were also told, "If someone rings in sick which happens quite a lot, it can be awful. We have so many turns to do, so many one to one's and lots of paperwork, sometimes there is just far too much we need to get done." Another member of staff said staff were very busy and constantly in a rush.

We found that staff had not always completed relevant training required to carry out their role effectively. At the time of this focused inspection 78 members of staff had not completed physical interventions training. A high number of incidents occurred within the service, the nature of these incidents meant that staff would potentially have to use physical interventions or restraint to prevent people from being harmed. Some people's care plans stated staff should use physical interventions to provide care and support. Failing to ensure staff had received training in this area meant that staff did not have the skills and experience to support people appropriately and it is unlawful to undertake physical interventions if appropriate training has not been undertaken.

This demonstrated a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing. We are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found that a member of staff had been employed even though their DBS contained a caution from Humberside Police for an incident which had occurred involving a serious assault. We also saw that one of the references was negative and the referee would not recommend the person for employment as they had a poor ability to demonstrate a patient and caring nature. They were also rated as 'poor' in term of honesty and integrity. We found there were no risk assessments regarding the recruitment of the staff member or protocols available to support the registered manager to make decisions around whether to employ people with convictions or cautions against them.

During this focused inspection we reviewed 11 recruitment files. We saw evidence to confirm before

prospective staff were offered a role within the service relevant checks were completed which included an application form, interview, two suitable references and a satisfactory disclosure and barring service (DBS) check. A DBS check is completed to determine whether an individual holds a criminal conviction, which may prevent them from working with vulnerable people. The regional director told us that any information of concern returned on the DBS check would be assessed and would not necessarily prevent someone from being offered employment. They said that a risk assessment would be produced and an enhanced level of support and supervision could be offered during the person's probationary period. We saw evidence to confirm that this occurred in practice. However, we found that conditions of staff's professional registrations were not reviewed which meant the service had failed to assure themselves and take steps to ensure any conditions of registration were being met.

At our comprehensive inspection of the service in September 2015 we saw that in Hilltop and Overfields there were specific enclosed units for vulnerable people with nursing needs and for males who experienced aggressive and disinhibited behaviours. However, people with similar needs and vulnerabilities were also placed randomly outside of these units. We could not establish why this had occurred or what considerations had been made regarding the risks prior to offering a person a particular bedroom. During this focused inspection the service's regional director told us, "We currently have 12 vacancies, which has allowed us to re-locate people to more appropriate areas of the service" and "Over the past six month period we have been reviewing people's needs and with consent have moved people. We have an all-male unit and continue to assess the most appropriate place for people to be." Evidence was seen to confirm one person had moved from one area of the service to a quieter area where less people walked past their room. Staff told us they believed this had a positive effect on the person's level of aggression and agitation.

At our comprehensive inspection of the service in September 2015 we found people were not protected from abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 13 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

Effective arrangements were not in place to ensure that appropriate decisions were made and recorded about the use of restraint. One person had a skin condition, their care plan stated in the needs section, '[name] is not always concordant with staff intervention meaning at times may need increased levels of support to apply. This may need the intervention of up to three staff members at a time, two staff supporting [names] hands and distracting their attentions whilst another staff member applies the creams'. The action and strategies section stated, 'Staff to be aware of aggressive behaviours and attempt leave and return techniques. Should [name] continue with these behaviours and all other techniques have failed; three staff should assist in applying cream'. The care plan failed to include what the 'other techniques' staff should try or identified timescales and did not include an instruction to complete a body map or check for injuries after the planned restraint had been carried out. Without adequate and detailed guidance to when the cream had to be applied the person was at risk of being restrained unnecessarily and inconsistently.

Another person's personal hygiene and dressing care plan stated, '[name] is mostly independent with washing however will need two or three staff member's assistance with showering and changing clothes regularly at times. [Name] does not like assistance and may become verbally aggressive and hostile occasionally resulting in physical aggression'. The action and strategies stated, 'Staff to use diversional techniques to encourage [name] to participate' and 'Staff to ensure if restraint is used that it is

proportionate at the time that it is needed'. A member of staff told us when providing personal care to the person, "Normally [name] will hold one person's hands and they will attempt to distract them whilst the other assists with changing but if they are very aggressive one person holds one arm, another will hold the other arm and the third person will change them as quickly as possible." The care plan informed staff to use proportionate restraint at the time that it is needed but failed to inform staff when the interventions should be used. Failing to provide detailed guidance for staff regarding when personal care was required could lead to interventions being used when the benefit of receiving the care did not outweigh the effect of being restrained.

We saw in one person's daily reports that they were incontinent but regularly declined to undertake personal care and refused staff's offers of assistance with this. The daily reports stated, '[Name of person who used the service] had been incontinent on their bed, staff have tried on numerous occasions to change bedding but refused. Under best interest [name] was assisted into the shower and all bedding changed. Three members of staff required.' There was no other information regarding this episode of care, body maps were not completed to review if the person was injured during this intervention or to record how long the intervention lasted. There was no evidence to show this decision was made by a relevant person such as the registered manager, there was no review of the episode of care to ensure appropriate action was taken and future interventions could be planned to reduce the impact on the person who used the service. Appropriate guidance had not been referred to and followed regarding the use of physical interventions [The Department of Health's 2014 guidance Positive and Proactive Care: reducing the need for restrictive interventions].

People were not always protected from abuse. Two people who were living with dementia had care plans developed regarding their 'sexualised relationship'. Records showed both people's families had informed the service they did not believe their relative had the capacity to make an informed decision regarding entering the 'sexualised relationship' and requested that the service ensure the relationship remained platonic. The service had failed to take appropriate action and both people were at risk of sexual abuse due to their lack of capacity.

We looked at another person's care plan because they had been involved in a number of incidents and received one to one support 24 hours a day. Their mental health care plan stated their 'hazards' were, 'verbal and physical aggression, agitation, aggression towards them, poor understanding of a third party motive and retaliation from others'. The 'action and safety strategies' section stated, 'Staff to ensure [Name of the person] receives reassurance and using appropriate diversional techniques when they present with any agitation and/or aggression' and 'Staff to allow [Name of the person] time and space alone if the diversional techniques are unsuccessful'. The care plan provided no insight in relation to how staff should provide reassurance or what diversional techniques were successful in re-directing the person. The care plan provided no insight into what could trigger the person to become agitated or aggressive and failed to include what indications staff should look out for which would indicate the person was becoming agitated or aggressive. The service had notified the CQC of a number of incidents the person had been involved in since the development of their care plan, which indicates that the service had failed to learn from incidents and take appropriate action to prevent the probability of their reoccurrence.

A person's communication plan stated that they could communicate verbally but at times because of a diagnosed mental health disorder they could be aggressive, hostile and use physical/verbal aggression towards staff and other people who used the service. The care plan informed staff to remain calm, use positive behaviour and report problems to senior staff when required. However, it did not provide examples of what positive behaviour was known to be effective or how staff should respond to the person's challenging behaviours. This meant the support the person received could be inconsistent and lead to their

challenging behaviours not being managed effectively.

On local authority completed Deprivation of Liberty Safeguard authorisations and associated mental capacity assessments; it stated they could be subject to restraint.

We asked the registered manager what physical intervention training staff had received and how they ensured interventions were completed safely. They told us that breakaway techniques training was being rolled out and they were aware that this needed to completed. Staff informed us that they had received training recently and showed us a technique they had been instructed to use. This technique involved holding someone's hand against their shoulder. We found no information in people's care records about this hold. This move can lead to staff inadvertently causing injuries to people. We were not clear if the trainer was accredited.

We found that no risk assessment had been completed, there were no documents that pictorially showed how to apply any holds and no guidance was available to instruct staff how to record information about the use of restraint and other forms of physical interventions. Any physical intervention poses a risk to someone's health and we would have expected these records to be in place. Including a very detailed record maintained for each occasion staff physically intervened and a debriefing following each incident in line with current good practice guidance [The Department of Health's 2014 guidance Positive and Proactive Care]. Also we would expect that an accredited trainer would deliver any training on the use of physical interventions. In light of the level of physical interventions being used, break away technique training would be insufficient to ensure staff safely managed aggressive outbursts and did not protect the individual from the risk of unapproved techniques or unnecessary force being applied.

This demonstrated a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. We are currently considering our regulatory response to this breach.

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of the service in September 2015 we found the service had failed to follow the principles of the Mental Capacity Act 2005 (MCA) and ensure the rights of people who lacked capacity were protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 11 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act balances an individual's right to make decisions for themselves with their right to be protected from harm if they lack mental capacity to make decisions to protect themselves.

The MCA 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. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. It sets out who can take decisions, in which situations, and how they should go about this. The Act generally applies to people who are aged 16 or older, and 18+ for Advance decisions, lasting powers of attorney and the deprivation of liberty safeguards.

At our comprehensive inspection we found staff were unclear about what action they needed to take to ensure the requirements of the Mental Capacity Act [MCA] 2005 and guidance from the MCA Code of Practice were followed. The training records we looked at showed that 53 staff out of 157 had not completed MCA / Deprivation of Liberty training. MCA is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances.

During this focused inspection we saw records confirming all staff had completed MCA training and staff had completed refresher courses as required. During discussions with staff it was clear they understood the importance of gaining people's consent before care and support was provided. A member of staff told us they would always ask before the provided any support and that if the person had been deemed to lack capacity, decisions could be made by appointed persons or in a best interest forum.

Although staff had undertaken relevant training regarding the MCA appropriate action had not been taken to ensure people who could not consent had decisions made on their behalf following the principles of the MCA. A relationship care plan was in place for one person, which had been created in September 2014 and re-written in October 2015 but no changes were made. The care plan stated the person had developed a 'sexualised relationship' with another person who used the service. The 'actions and strategies' section stated, 'Staff to be aware the mental health team are being contacted to ascertain whether both parties

have capacity regarding their action'. This was stated in September 2014 but the care plan had not been updated following their advice and guidance. There was no evidence to show that a best interest decision was in place regarding either person entering into a 'sexualised relationship' or whether they were able to consent to this. Records showed both people's families had stated their desire for the relationship to remain platonic.

The service failed to protect people who did not have the capacity to understand the consequences of their actions and failed to implement the known wishes of relevant people who knew the person's preferences before they became incapacitated.

At our comprehensive inspection of the service in September 2015 we saw that a number of people had safety stairgates across their bedroom doors and we were told this had been done at the request of the person or their relative. At this inspection we found that some of the stairgates had been removed but were told that some people had asked that these remain in situ. We reviewed one person's use of a stairgate we found this person was physically disabled and remained in bed throughout our visit. The person's evacuation plan stated the person needed to be placed on a mattress and pulled to a place of safety in an emergency situation; it did not mention how to get the mattress past the stairgate. The care record did not contain any formal document to show the person had consented to the use of the stair gate but there was a file note typed by the registered manager stating the person said they wanted this gate to remain. This was not signed by the person and when we asked the registered manager about this they told us the person was unable to sign documents because of their disability. The document did not discuss whether the person had been involved in a full discussion about the potential risks of having a stairgate in place such as difficulty evacuating the bedroom in the event of a fire. We found no information to show this person had made an informed decision about the use of this equipment.

Appropriate action had not been taken to ensure when consent could not be provided by people due to their lack of capacity to make an informed decision, best interest decisions were in place. A person's personal hygiene and dressing care plan stated the person was mostly independent with washing however required the assistance of two or three staff member's with showering and changing clothes. The plan stated the person became verbally aggressive and hostile occasionally resulting in physical aggression during staffs interventions. A member of staff described how personal care would be provided, they told us, "Normally [name] will hold one person's hands and they will attempt to distract them whilst the other assists with changing but if they are very aggressive one person holds one arm, another will hold the other arm and the third person will change them as quickly as possible." There was no evidence that providing personal care using restraint was in the person's best interest or that relevant people had decided this in a best interest forum; when the person's health was at risk and required the intervention of three staff.

One person who used the service suffered from a skin condition; their care plan stated that they regularly refused to have the cream applied to manage their skin condition. The care plan stated, 'when required three staff should assist in applying cream, two holding the person's hands whilst the third applied the cream'. There was no record that a best interest decision was in place to apply the cream by using restraint or that this was the least restrictive and most appropriate way to meet the person's needs. The care and treatment being provided was not appropriately authorised and was carried out without consent.

A person's daily reports stated they had been incontinent and declined to allow staff to provide personal care. A decision was made, 'under best interest' and three members of staff used physical interventions to deliver personal care. There was no evidence to show this decision was made by a relevant person such as the registered manager (who can make decisions in people's best interest in emergency situations when there is no time for a best interest meeting to be held). There was no record of a best interest meeting having

taken place after the event to decide what action should be taken if the situation reoccurred.
This demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent. We are currently considering our regulatory response to this breach.

We found evidence in one person's care plan that they regularly declined to take their prescribed medicines. Records showed the person's family had been contacted as well as their GP and other relevant professionals and a decision had been made to administer medicines covertly. Involving relevant professionals and people who have an interest in the person's care helped to ensure the decision was made in the person's best interest.

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).
At our comprehensive inspection of the service in September 2015 no records had been kept in respect of the DoLS authorisations applications that had been made and when these expired. It was difficult to find the documentation as this was not stored in the care records. Since the last inspection the registered manager had set up a file, which contained a matrix for tracking this information and a copy of all of the applications and authorisations.

During this focused inspection 28 of the people using the service were subject to a valid Deprivation of Liberty Safeguards DoLS order. In addition to this 62 DoLS authorisations had been applied for with most being in October 2015 but one application dated back to December 2014. We found that an additional four DoLS authorisations had expired and two applications had been declined. From our discussion with the registered manager we found that despite making telephone calls asking when these would be completed they had not proactively dealt with the matter so had not used urgent authorisation applications in respect of the continued deprivation these people were experiencing. We also found that no applications had been made for renewal of the four authorisations.

We checked whether the staff understanding of who was subject to a DoLS authorisation and whether any conditions on these authorisations were being met. None of the staff we spoke with were aware of the person's right to contest the DoLS and that the relevant person's representative (who could not be the family member that was involved in the placement) could apply to the Court of Protection for a review of this order. Staff we spoke with had some understanding of DoLS and why they needed to seek these authorisations. However, the staff we spoke with were unsure as to who had a DoLS authorisation in place and believed that an application meant the authorisation was agreed, which is not the case.

The regional director told us that they recognised the manager and staff needed more support to ensure they fully understood and applied the requirements of the MCA.

This demonstrated a breach of Regulation 13 (Safeguarding people from abuse and improper treatment); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found that the service had failed to provide person centred care and treatment. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory

improvements in relation to the requirements of Regulation 9 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found that care plans were generally detailed and comprehensive. However, the evaluations lacked detail and failed to demonstrate improvements or deteriorations in people's health or behaviours. During this focused inspection we found care plans did not include a current and accurate description of people's needs and failed to provide relevant information to enable staff to support people effectively. For example, after a person returned from hospital following a routine operation, the service failed to update their care plans to reflect their enhanced support needs. Relevant professionals were not contacted for their advice and guidance during the person's recovery which would have ensured they received the most effective support. Failing to update people's care plans as their needs change or following stays in hospital could lead to staff providing inappropriate care.

We found a range of contradictory information in one person's care plans and a failure to incorporate required information. Their mobility care plan stated the person required 'support from staff to rise from sitting or lying positions' and 'mobility is decreasing and requiring more assistance to mobilise from staff and hand rails. Their pressure care, care plan stated they 'mobilises independently' and will 'on occasion walk throughout the home'. Their physical health care plan stated they 'are able to mobilise independently'. However, we found a 'physio tools' personal exercise programme had recently been introduced which required the person to complete a set of exercises. Their physical health care plan evaluation sheet contained no reference to the physiotherapist's instructions which could lead to the person not being supported to complete the exercises required to ensure their mobility was improved and maintained.

We reviewed the daily reports for one person who used the service, over a period of four months they were recorded as urinating and opening their bowels in in-appropriate locations on numerous occasions. We reviewed their toileting care plan which had not been updated for six months. The care plan did not state that the person urinated or opened their bowels in in-appropriate locations and did not contain guidance for staff regarding the support the person needed. We also checked their personal hygiene and dressing care plan which records the support people require with toileting and continence issues. The information recorded in the daily notes was not recorded in either care plan and no guidance had been created informing staff of how to manage this behaviour. The care plan evaluation form showed the care plan had been reviewed six times without being updated to reflect the person's current support needs.

One person received 24 hour one to one support due to their level of need. We reviewed their care plans and saw that their physical health care plan stated in the 'action and strategies' section 'two carers assist [name] when walking around (when required)'. Their pressure care; care plan stated in the 'needs and choices' section '[name] mobilises independently'. Their toileting care plan stated in the 'needs and choices' section, '[name] will at times defecate in communal areas then seek out a member of staff to tell them'. From the contradictory information it is difficult to ascertain the level of support the person needs when mobilising. The person received one to one support 24 hours a day which would enable staff to support the person to a toilet instead of allowing them to defecate on the floor.

Another person's toileting care plan stated in the needs section, '[name] is doubly incontinent and due to this wears incontinence pads', '[name] is not able to use the toilet and will need the assistance of two staff to carry out personal care tasks' and '[name] is not concordant with their personal hygiene and becomes both verbally and physically abusive often, kicking, scratching and spitting at care staff'. The person's mental health care plan stated, '[name] at times will hit, scratch, bite and slap' and '[name] has renal

impairment and this can maximise their symptoms making them become overly agitated and aggressive towards others'. Neither care plan incorporated guidance to enable staff to manage the person's behaviours in an appropriate and consistent way.

A person's communication care plan contained contradictory information. The 'needs' section stated, '[name] no longer understands what is being communicated to them and does not retain information. [Name] can no longer make small informed choices and will need staff to anticipate their needs.' The 'action and strategy' section stated, 'staff to encourage [name] to communicate their needs if possible'. We observed staff interacting with the person and saw the person smiling and using eye contact with staff. If the person can communicate their needs via non-verbal methods this should be recorded in their care plan to ensure all staff are aware of how to support the person and meet their needs as effectively as possible.

People were not always supported to have sufficient to eat and drink and maintain a balanced diet. We saw that a person had been referred to the nutrition and dietetic service and a confirmation letter had been sent to the service in January 2015. We checked their eating and drinking care plan which was last updated in October 2015, the care plan made no reference to this referral or the person losing weight. The 'needs' section of their care plan stated [name is able to eat and drink independently but they can have a varied appetite', '[name] is able to state if they are hungry or thirsty but will often choose not to eat or drink anything' and '[name] was on protein supplements that were prescribed by the dietician but they didn't seem to have any interest in them'. There was no evidence action had been taken when the person declined the supplements or there had been any further contact with the dietetic service. The care plan lacked insight into the person's current needs and failed to provide adequate guidance to staff regarding how to support them effectively.

When people's needs changed or developed, referrals to dieticians or speech and language therapists were not made in a timely manner. We requested all of the daily reports for one person who used the service. The daily reports we were provided with covered a 50 day period, from that period we saw recordings had been made on 27 dates. The person was recorded to have eaten, 'well' or 'had a good diet' on 24 occasions. Over the same period the person lost 12.95kg (over two stone or roughly one sixth of their body weight). When the weight loss was identified the daily report stated, 'suggest food and fluid chart'. It was not until the person had lost 24.25kg that a referral was made to a speech and language therapist for advice and guidance. The person's eating and drinking care plan stated the person, 'ate well' and no concerns regarding their dietary intake was recorded. Their care plan evaluation sheet stated they had, 'lost a considerable amount of weight' and 'continue care as stated', during this time no referral had been made to a relevant healthcare professional. Failing to take appropriate action when people's needs change could lead to them receiving inappropriate and ineffective care and had adverse effects on their wellbeing.

Menus were on display in the dining area which listed what choices of food were available each day. We saw no pictorial aids were in use which could help people who were living with dementia to make choices and help them to remember what options were available. An area of the service had an open plan kitchen with servery which contained fresh fruit, pre-prepared sandwiches and jugs of orange and blackcurrant juice for people to help themselves. We observed people making their own drinks using the kitchenette area in the dining room.

At our comprehensive inspection of the service in September 2015 we found that people were not always supported by adequate numbers of suitably trained and experienced staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory

improvements in relation to the requirements of Regulation 18 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 it was evident staff had not received training in relation to specialist conditions including mental health and associate conditions such as Asperger's and Autism. The staff we spoke with said they would welcome more training on the different conditions the people they supported have. During this focused inspection we were told new employees were enrolled onto the care certificate programme as part of the 13 week induction with the service. The programme was completed online and had the facilities to allow the registered manager to log in and check people's progress. Staff's skills were developed in a number of ways including observed practice, group workshops, meetings and competency assessments.

The director of the registered provider's 'quality matters' programme told us, "I started in July 2015 and am responsible for training improvements, sourcing training and ensuring this is delivered and understood across the organisation. I have been spending a lot of time at the service to ensure staff training priorities are met and training theory is being put into practice by staff at the service."

During discussions staff told us they received regular supervision and one to one support; records we saw confirmed this. We saw staff supervisions were focused on specific topics such as eating and drinking or providing pressure care. Ten at ten meetings (ten minute meetings for senior staff and management discuss any issues with people's care and support issues) were held daily to ensure all senior staff were aware of any changes to people's needs and could disseminate this information to all staff.

The nominated individual told us, "We have developed a clinical excellence programme to evaluate our nursing staff. We want to increase the effectiveness of our medication administration and reduce the number of falls and hospital admissions through proactive work. We have increased our nursing rates (hourly pay rates) so we can retain and recruit quality staff" and went on to say, "We are also working with Age UK to develop a dementia programme."

A relative told us, "After some concerns early on with how they managed his diabetes, a diabetic nurse was contacted and training was given to the staff which I thought was really positive."

Requires Improvement

Is the service caring?

Our findings

When we asked a visiting relative if they thought the staff were caring they said, "Caring? I've never questioned that." Another relative commented, "He [the person who used the service] has a good rapport with the staff."

At our comprehensive inspection of the service in September 2015 we found that people were not always treated with dignity and respect by staff. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had made improvements in this area but had not taken sufficient action to meet the shortfalls in relation to the requirements of Regulation 10 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we observed staff failing to take action to protect people's dignity. During the inspection we noted a strong odour of faeces in the upstairs lounge on Hilltop. We brought this to the attention of the support staff who proceeded to walk around the lounge smelling each of the people in the room. They identified who required support with personal care but failed to take action or ensure the person received the support in a timely way. A person was sitting in a position which exposed their bare legs and continence pad. Another person was asleep on their bed; they were lying in a position which compromised their dignity by exposing their underwear for an extended period which went unnoticed by staff.

On the second day of this focused inspection at 5.30am an inspector asked a member of staff why some people were in the lounge asleep in chairs. The inspector was given a piece of paper containing hand written instructions for night staff. The paper stated if people needed support with personal care during staffs routine observations or when people required re-positioning (to decrease the possibility of them developing pressure sores) staff were to get them up and dressed and leave the person on their bed if necessary. The paper directed staff to carry out a specific action without regard to the person's wishes or preferences and failed to encourage staff to treat people with dignity and respect during their interactions.

Staff did not always communicate with people or enable them to make decisions in their daily lives. On the third day of our inspection we saw one person who could no longer communicate verbally sitting in their wheelchair in a quiet area of the service. A member of staff came into the room and without speaking to the person or trying to ascertain if they wanted to be moved, wheeled them out of the room into another area of the service.

We spent time observing the level of support and interaction people received in a communal lounge in the morning. The TV was on, which some people were watching while other people were sat asleep in arm chairs or two setter settees. During this time no meaningful activities were taking place and people appeared to be under stimulated. After lunch we returned to the communal lounge and noted that the

chairs and settee's had been rearranged and were now facing one another. Staff we spoke with told us this was done routinely by domestic staff so they could clean the floor. Consistently re-arranging furniture and leaving it in different positions can be dis-orientating for people who are living with dementia and could add to people's levels of confusion and agitation.

During our observations we saw staff missed opportunities to engage with people. We saw three staff come in to a lounge at different times and each member of staff sat next to the same person and spoke to them on an individual basis. One of the other four people in the lounge asked the member of staff if they came from Scunthorpe; they confirmed they did, so the person asked if they remembered the name of a particular public house. The member of staff said no and returned to talking to the person they had sat next to. The person who asked the question went back to staring out of the window and just looking around. The member of staff could have used the question to engage with everyone in the room and begun a discussion about what people remembered supporting them to reminisce.

We repeatedly saw one person presenting in a distressed state during this focused inspection. Staff, including the registered manager and regional director understood the person's anxieties and used the same technique which was known to reassure the person. It was clear there was a good understanding of the most effective way to support and comfort the person.

During this focused inspection we saw staff were attending dignity in care training and were told all staff would have completed this training by first week of March 2016. During discussions staff described how they would treat people with respect and maintain their dignity. Examples included, "Supporting with personal care in bedrooms", "Make sure people are encouraged to do as much as they can themselves", "Closing curtains and getting things such as towels ready before providing care" and "Keeping things confidential; not speaking about people out of the service".

Throughout this focused inspection we saw people who were dressed in clean clothes and looked presentable. Ladies wore make up, had their nails painted and wore jewellery. However, we saw one person whose trouser zip was either down or broken, their shirt was not tucked in and their underwear was showing. They had not had a shave, their hair was unkempt and their finger nails were dirty. We saw staff speaking to the person on several occasions but they did not offer support to the person or take action to uphold their dignity.

The nominated individual told us, "We have implemented a 'sit and see' programme, it was due to be rolled out in April but we brought it forward to assure ourselves of what is happening in the service." The director of the registered provider's 'quality matters' programme told us, "The sit & see programme is not yet live in the service. All of the directors and the quality matters team have completed the training. The programme will be rolled out across the organisation; commencing at Phoenix Park." The 'sit and see' programme has been created to capture the daily interactions between the people who use the service and staff. After observing and recording the interaction feedback will be provided based around key areas such as staff abilities to, amongst other things, having zero tolerance regarding abuse, promoting people's independence, respecting privacy and alleviating people's loneliness and isolation. We saw evidence that some observations had been completed and preliminary feedback provided to staff.

At our comprehensive inspection of the service in September 2015 we found that the service had failed to provide person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory

improvements in relation to the requirements of Regulation 9 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

We looked at 15 care plans and found they contained differing amounts of information. Some plans included, 'getting to know you' pages which provided personal information about people's lives before they moved into the service. Details of people's family life, specific events, where they went to school and where they grew up, previous occupations hobbies and interests were recorded. However, the registered manager explained, "We do know more about some people than others, I know we need to work on that."

We saw one person's communication care plan which had been updated in January 2016 contained inappropriate language and failed to take into account the person's mental health condition when describing their behaviours and actions. The 'needs' section of the care plan stated, 'at times [name] will mimic others and can also be manipulative, insulting and has recently begun to be vulgar'. The 'actions and strategies' section contained no guidance for staff to follow when the person used inappropriate and disinhibited language; which could lead to the person's behaviours being managed inconsistently.

This demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent. We are currently considering our regulatory response to this breach.

Requires Improvement

Is the service responsive?

Our findings

A relative we spoke with said, "Things have not always been perfect and mistakes have been made but I gave a list of issues I had to the manager and I'm confident that they will get fixed. I want to work with them to get the best care we can for him [a person who used the service]."

At our comprehensive inspection of the service in September 2015 we found that the service had failed to provide person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 9 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found care plans were generally detailed and comprehensive. Evidence of regular reviews and evaluations were documented, however some of the evaluations lacked the detail to demonstrate improvements or deteriorations in behaviours or health. At this focused inspection we found people did not receive personalised care that was responsive to their needs. Care plans were not updated as required and the reviews that were undertaken failed to ensure accurate instructions and guidance were available to enable staff to meet people's needs. When people returned from hospital their enhanced levels of need had not been documented and their care plans were not updated. We found evidence that accidents and incidents were not used to develop people's care plans and learning had not been implemented or incorporated to provide improved information for staff which could enable them to meet people's needs more effectively.

We found a number of examples where the service had failed to be responsive regarding the changing and evolving needs of the people who used the service. For example, during observations we noted one person used aggressive and abusive language towards staff. The registered manager explained that the person had been issued with 28 days' notice to leave the service. The registered manager informed us that the person responded abusively to people in positions of authority and regularly stated that they wanted to leave the service. A member of staff told us the person often declined prescribed medication and that they did not know how to manage their behaviours. They also said, "The manager told me [Name of the person] has been given 28 days' notice due to their un-manageable behaviour" and "The manager said senior staff and management can't talk to them as it exasperates their behaviours." We reviewed the person's communication and mental health care plan; neither document had been updated for over four months and the care plan evaluations stated, 'plan remains accurate'. As the person's needs developed appropriate changes should have been made to the care plans to enable staff to deliver effective and consistent support to the person.

Another person had displayed behaviours that were challenging to the service and others; had been involved in verbal and physical incidents and the registered manager believed their needs could no longer

be met by the service. When we checked their care plans there was very little information regarding the services inability to meet the person's needs and no evidence of the different ways the service had tried to manage the persons behaviours before they had decided they could not meet the person's needs. This demonstrated a failure to respond to the person's needs and take appropriate action in a timely way.

It was recorded in one person's covert medication care plan in the 'needs' section, '[Name] finds some of the liquid medication difficult to accept due to it being unpalatable'. In the care plan we found a letter to the person's GP written by a community mental health nurse requesting that one of the person's prescribed medicines be supplied in a tablet form. This was a period of four months after the service were aware the person regularly refused to take their prescribed medication. We completed our focused inspection a month after the letter was written to the GP and the person's covert medication care plan had not been updated and there was no evidence to show the mental health nurse's request had been followed up.

We saw one person's level of mobility had decreased and they required one to one support to maintain their safety. Their toileting care plan had not been updated when their mobility support needs increased and was no longer reflective of their current needs. Their toileting care plan stated they had become disoriented on a number of occasions and defecated in inappropriate areas of the service. With one to one support 24 hours a day and their decreased level of mobility defecating in a communal area would not be possible. This meant the information in the toileting care plan was inappropriate and updated guidance had not been created for staff to follow.

A relationship care plan had been written for one person in September 2014. The plan stated, 'Staff to be aware that the mental health team are being contacted to ascertain whether both parties have capacity regarding their actions with one another'. The care plan was updated in October 2015 and contained the same statement. There was no evidence to show that advice and guidance from the mental health team had been received, considered or utilised to provide appropriate support to the person.

This demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. We are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found there were very few dementia friendly activities taking place and there was no rummage boxes or tactile items for people to use. We saw a games room with a dart board and pool table, but we did not see anyone using these facilities. During this focused inspection we did not see any people utilising the games room but we did see an enhanced activities programme was in place. The February activities included, movie day, bingo, relaxation, sing a longs, afternoon tea dances and cocktail afternoons. Calendar events such as St George's Day, St Patricks Day and Valentine's Day were also celebrated. For Valentine's Day a photo booth had been made, roses were ordered for people to give to their loved ones and a special evening menu had been prepared. We saw people were often disengaged during this focused inspection and observed people sleeping in lounges, with very few activities seen. Due to the size of the service, the differing levels of people's ages and abilities providing one main group activity each day may not be the most suitable way to meet people's social care needs.

During this focused inspection we saw a new fireplace being delivered to the service. The registered manager explained that as part of a craft activity the people who used the service and staff had made a life sized fire place in cardboard. They said the people who used the service liked it and often tried to put things on the mantle top and were seen rubbing their hands in front of the mock fire. The registered manager said they ordered a real fire place as the ones people had made were becoming worn and needed to be disposed

of. The registered manager confirmed that although the fire was not real and didn't give out heat, it did light up and give the effect of an actual fire.

Inadequate

Is the service well-led?

Our findings

A visiting relative told us, "I read your last report; I thought a lot of the problems were down to the management and the administration [of the service]. If they get those things right I am sure things continue to improve."

At our comprehensive inspection of the service in September 2015 we found that the registered provider had failed to operate good governance systems in the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this focused inspection we found that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 17 described above. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach.

At our comprehensive inspection of the service in September 2015 we found evidence that confirmed the service was in breach of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this focused inspection it was evident that the required improvements had not been made to ensure people were supported in line with the regulations of the Health and Social Care Act. The service remains in breach of the regulations identified at our comprehensive inspection of the service in September 2015. The registered provider has failed to ensure effective systems or processes were in place to assess, monitor and improve the quality and safety of services provided.

At our comprehensive inspection of the service in September 2015 we found governance systems utilised within the service were not effective. During this focused inspection the nominated individual told us, "I am confident and comfortable with our quality assurance systems. The regional director has spent a very long time in the service reviewing the quality and the structure. A review of things was possibly overdue but we are looking at things now and if we find any gaps we will plug them."

During this focused inspection we found evidence to show that the care plan spot checks introduced following concerns raised during our comprehensive inspection were ineffective. The spot checks failed to ensure that care plans were accurate and reflected the persons current support needs. A team leader explained, "After the last inspection we started to do spot checks on the care plans, just to see what changes were needed. We have probably looked at two thirds so far" and went on to say, "When incidents occur we update care plans and contact professionals for advice." We saw evidence that in some instances relevant professionals had been contacted to inform them of the changes in the person's behaviours and meetings were held to discuss the most appropriate way to support the person. However, this information had not been used to update people's care plans and appropriate guidance had not been developed to enable staff to manage people's changing needs and enhanced behaviours. Which meant professional advice was not used to meet the needs of the people who used the service as required.

The care plan evaluations failed to ensure that accidents, incidents and other important events were used to

ensure people's care plans were accurate. For example, we found that an incident had been recorded due to a person developing a red area on their sacrum. We checked their pressure area care plan which stated the person had been assessed as being at 'very high risk' of developing pressure sores. The care plan included the aids that were required to be in place as well as the monitoring to be completed and instructions for staff to ensure the person's personal hygiene was maintained. A care plan evaluation was completed two days after the incident form had been completed but the evaluation failed to mention the changes in the person's needs or provide further guidance for staff to ensure the area did not deteriorate further.

Appropriate systems had not been implemented to ensure that people's care plans and risk assessments were accurate and contained people's current support needs. There was no system in place to ensure accidents and incidents were learned from and used to prevent their future re-occurrence. When incidents occurred the service failed to develop effective behaviour management plans and when people were discharged from hospital a review of their needs were not undertaken and their care plans were not updated.

At our comprehensive inspection of the service in September 2015 it was clear the general understanding of the MCA throughout the service was inadequate. During this focused inspection it was evident that effective systems had not been developed to ensure compliance with the requirements of the MCA. Emergency DoLS had not been applied for as required and when DoLS applications had been rejected action had not been taken to follow this up.

During a discussion with the nominated individual and the regional director we highlighted some of the inconsistencies, inaccuracies and failures to update people's care plans to reflect their current support needs. We spoke about one person who had been issued with 28 days' notice, the regional director told us, "[Names] care plan must have been reviewed by 12 people [staff at the service]; no one has picked up the problems." The person's care plan contained a distinct lack of evidence regarding the behaviours that had led to the registered manager deciding the service could no longer meet the person's needs.

In response to our concerns the nominated individual informed us, 'All care plans will undergo a complete review, re-evaluation and audit.' The regional director told us, "The responsibility for updating care plans and completing reviews was everybody's [all staff] now we have team leaders here it will part of their role to ensure they are up to date" and "I have not case tracked anyone." The nominated individual said, "We have recently introduced the team leader role, the structure replicates the model in our more successful services and part of their role will be to check care plans are written and updated appropriately."

We found that auditing tools were not always used effectively to improve the level of service provided. For example, we discussed the infection control auditing tool with the registered manager. They told us, "We know staff can wash their hands in people's rooms after personal care because everyone has an en-suite, so we score highly on the first part of the audit, we don't have to check." We found staff could not gain access to two people's en-suite due to mobility equipment being stored there and were told it also happened in a third persons room. Failing to use auditing tools effectively can lead to areas of poor practice being missed. The services hospitality manager told us, "When I am doing the infection control audit I have seen equipment stored in people's en-suite, I have told staff not to do it; I have found things like that before and it was all removed they must have put it back in there" and went on to say, "Trying to explain infection control to some of the staff is really difficult."

The regional director told us that the management and staff shared an understanding of the key challenges and risks to the service. In 2014 a person who used the service died after ingesting a disposable glove. The regional director explained that the incident had affected everyone at the service and action had been taken

to ensure that the possibility of reoccurrence was minimised. Procedures were implemented for the storage and disposal of gloves and staff understood their responsibilities to ensure people who used the service did not have access to disposable gloves. During the comprehensive inspection of the service in September 2015 we found that staff had failed to ensure gloves were stored in appropriate locations and were accessible to people who used the service. During this focused inspection we found cupboards containing gloves were left unlocked and found gloves in a bathroom. In February 2015 a person who used the service drank cleaning fluids. This demonstrated that the service failed to learn from serious incidents and take appropriate steps to prevent their reoccurrence.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach.

We spoke with the regional director regarding the service's failure to ensure the conditions of a nurse's registration were being monitored effectively. They told us, "The HR director monitors our recruitment; I am not sure why we haven't set up an occupational health contract, we should have one. We should have had a plan to help them meet the conditions. We would usually ask staff to bring in evidence to show they are meeting any conditions." The HR director said, "The requirement to set up occupational health contracts and monitor any requirements should be done by the service." The service's clinical lead told us, "I have not checked they are meeting their conditions" and "I haven't asked them to provide evidence they were meeting the conditions." The systems used by the service to ensure conditions on staff's professional registrations were being met were ineffective. The service failed to ensure conditions on staff's professional registration were being met and if staff were failing to adhere to their professional registration the service would have not been aware of this. After the inspection the regional director sent us information regarding this matter, however, the service failed to take action until this was highlighted to them.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of this report.

At our comprehensive inspection of the service in September 2015 a number of documents were requested from different members of the inspection team, but many of these were not provided following numerous requests. We also provided the registered manager with a list of documents we required to review on day one of our inspection, but we did not receive everything requested. A revised list of documents still required for day two of our inspection was also requested, but again some of these documents were not provided or made available, even though they had been requested in advance. We found that the registered manager did not provide documentation in a timely way. Following the inspection we had to request further evidence using our regulatory powers, in order to complete our inspection process. During this focused inspection we received some of the information we requested in a timely way but continued to experience issues with the registered provider's inability to produce all of the evidence we requested. Again we had to use our regulatory powers when requesting further evidence.

We asked to see evidence that the board of directors and senior management were aware of and took responsibility for what that happened in the service. The nominated individual told us, "We have a strategic board and an operational board. Issues such as incidents occurring in services would be discussed at regional directors meetings." A regional director explained, "The minutes of the meetings get sent to the nominated individual for review so he is aware of what has happened."

The registered provider's chairman visited the service during our inspection, they told us, "When I visit any of our homes I ask myself three things; what can I smell? What can I hear? Do the staff make eye contact with

me?" They went on to say, "Whenever families speak to me, if they raise concerns I make sure it gets followed up and they get a response." The chairman also said they encouraged the registered provider's regional managers to spend nights in the service which would enable them to gain and understanding of the service and provide feedback to the service's registered managers.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices were not established and operated effectively. Regulation 19 (2) (3) (a) (b).