The Red House Nursing Home (Northants) Limited

The Red House Nursing Home

Inspection report

Highcross
Syresham
Brackley
Northamptonshire
NN13 5TJ
Tel: 01280 850375

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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

Overall summary

We carried out an unannounced focussed inspection on 25 August 2015 in relation to information of concern we had received from other agencies; their concerns were that the service did not have adequate management. The manager subsequently appointed a consultancy company to oversee the management of the service. We continued to monitor the service and allowed time for the consultancy to establish their role in the home. We revisited the home to carry out a full comprehensive inspection on 7 October 2015.

This inspection follows our comprehensive inspection in February 2015 where we found the service Required

Summary of findings

Improvement in all areas. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for The Red House Nursing Home on our website at www.cqc.org.uk

The Red House Nursing Home provides accommodation for people requiring personal care and nursing care. The service can accommodate up to 25 people. At the time of our inspection there were 15 people using the service, of which nine required nursing care. The service provides nursing care to people that are living with dementia and enduring mental health and physical conditions.

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.

There was a lack of consistent managerial and clinical leadership and oversight of the quality and safety of the care being provided.

The Registered Manager had been repeatedly absent from the home over the last few months due to understandable circumstances. They had not made provision for the day to day management of the home in their absence leaving staff at the home without clinical leadership and managerial guidance. This had led to a failure of all the systems that were designed to keep people safe. Records relating to all areas of the business were in disarray. People were at risk of missing health appointments as they did not always receive their correspondence.

The appointment of the consultants came at a time when most of the staff that knew people and understood their needs had left the service. The consultants had been given the managerial role without the adequate finances for repairs or control of the duty rota. Improvements to the service were starting to take effect, however we found areas for improvement that had not yet been identified.

The provider had failed to ensure that the home was maintained in a condition which protected the health and safety of people living in the home. Timely repairs had not been carried out even though they had been brought to the attention of the provider. People were at risk of infections as the mattresses that were not clean had not been replaced.

People had not always been properly assessed for their suitability to live at the home, as people had been admitted to the home without adequate staff skills or experience to meet their needs, in particular those with complex behaviour or mental health needs. There was a lack of stability of the staff group which had impacted on people receiving a continuity of care. Staff had not been supported to carry out their roles as they had not received adequate supervision.

People's risks were not always being reviewed and plans to mitigate the risks were not recorded, leaving people without plans to prevent pressure ulcers or falls. People did not receive consistent care because the systems in place to assess their needs and to ensure that care was provided in line with their needs and preferences were disjointed.

People were at risk of not eating and drinking enough to maintain their health and well-being as staff did not carry out accurate risk assessments or refer people to health professionals in a timely way. Staff did not provide an environment that would promote eating or provide foods that were suitable for people's needs or follow medical advice for fluid regimes.

People were at risk of being cared for by people who had not undergone the appropriate checks as the records were not able to demonstrate that the registered manager had carried these out. Not all staff had undergone checks with the Disclosure and Barring Service (DBS) in relation to their employment at the service. Not all staff had recruitment records that demonstrated their suitability to provide care.

People could not rely on staff responding to their complaints as staff did not adhere to their policy and the provider did not respond to people's complaints.

We identified that the provider was in breach of seven of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3). We have commenced the process of cancelling the registration of the provider and Registered Manager.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People were not safeguarded from potential harm as staff had not recognised when people had been at risk of harm.

People were at risk of harm as the provider failed to protect the health and safety of people living in the home harm as maintenance had not been carried out in a timely way.

People were at risk of infections as the mattresses were not clean.

There was no clinical lead or enough skilled and experienced staff to provide for people's needs.

People could not be assured that the recruitment processes had protected them from staff that did not have the skills, experience or good character to provide safe care.

People's risks assessments were not always monitored and there were no management plans to mitigate the risks.

There were appropriate arrangements in place for the management of medicines.

People were assured that staff had access to emergency equipment.

Is the service effective?

Inadequate

The service was not always effective.

People received care from care staff that had not undergone the training they needed to meet people's needs.

People received care from staff that did not receive the supervision and support to carry out their roles.

People had not always been properly assessed for their suitability to live at the home.

People were at risk of not eating and drinking enough as staff had not carried out accurate risk assessments or referred people to health professionals in a timely way.

The interim managers knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS), however staff knowledge was not evident.

People had access to their GP every week.

People were assisted to attend healthcare appointments at hospitals and clinics.

Summary of findings

Is the service caring?

Requires improvement 

The service was not always caring.

People's care and support did not always take into account their individuality and their diverse needs as people were not always supported to maintain relationships with their families or maintain their hobbies and interests.

People's belongings were not always cared for or respected.

The noise level in the home was unpleasant due to the constant sound of the alarms on bedroom doors from the fire door closing devices, which staff had failed to rectify.

People's privacy and dignity were respected.

People were supported to make choices about their care and staff respected people's preferences.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People's care plans did not provide staff with the information they needed to provide care that would meet people's needs.

People could not rely on staff responding to their complaints as staff did not adhere to their policy and the provider did not respond to people's complaints.

People had the opportunity to be involved in their care planning.

People's decisions about their care had been taken into consideration.

Is the service well-led?

Inadequate 

The service was not well led.

The Registered Manager had been repeatedly absent from the home over the last few months. They had not made provision for the day to day management of the home in their absence leaving staff at the home without clinical leadership and managerial guidance.

People were not protected from the risks of events that may disrupt the service as the provider had not put a business continuity plan in place.

A consultancy company had been appointed to manage the home and improvements were being made, however we found areas for improvement that had not been identified by the consultants.

There was no system in place to ensure on-going maintenance of the home as the registered manager had not made provision for repairs.

There was no system in place to ensure that people's correspondence was dealt with in a timely manner.

Records relating to all areas of the business were in chaos resulting in a lack of secure and adequate information about staff employed at the service.

Summary of findings

There was no system in place to ensure people's belongings were respected and well cared for.

People and their relatives had been given the opportunity to feedback about their experiences at the home, and they had been kept informed of the changes in management.

Staff had been given the opportunity to provide input into the changes and development of the service.

The Red House Nursing Home

Detailed findings

Background to this inspection

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection was carried out by two inspectors and took place on the 25 August 2015 and 7 October 2015. Before our inspection, we reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners who help place and monitor the care of people living in the home that have information about the quality of the service.

During this inspection we spoke with five people who used the service and two of their relatives. We undertook general observations in the communal areas of the home, including interactions between staff and people. We looked at the care records of six people and the recruitment and training records for six members of staff. We spoke with the registered manager, three consultancy staff and two nurses and three care staff.

Inadequate

Is the service safe?

Our findings

The provider had failed to ensure that the home was maintained in a condition which protected the health and safety of people living in the home. Consultants working for the provider carried out a health and safety audit on 31 August 2015. This identified that some of windows on the first floor could not close properly and there were window restrictors missing from the frames.

On 7 October 2015 it was evident that the work had not been carried out to repair the windows and window restrictors had not been fitted even though they had been identified as a risk.

One person told us "the window is broken, if you try and open it properly it will fall off." We observed that their window was not aligned to the window frame. We observed another person had their window wide open, they told us "the window won't shut properly, its either wide open or stuck shut". During this visit we noted that there were six people residing on the first floor, four of whom were living with a dementia. The condition of the windows exposed these individuals to unnecessary risk of harm and serious injury.

The health and safety audit also identified that the fire exit door on the first floor was not alarmed. We found that on opening this door, it led to an iron staircase outside; there was no alarm to indicate that the door had been opened. People were at risk of exiting from the first floor without staff being aware and there was a serious risk to their safety if they tried to use the staircase without staff support to do so.

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

People were at risk of infections as the mattresses were not clean. The consultants had carried out a mattress audit on 4 September 2015. They found that nine mattress covers had leaks; there was extensive staining on the foam part of the mattress from bodily fluids. We examined the mattresses and found them to still be in the same condition on 7 October 2015. People had not been protected from poor standards of cleanliness and were at risk of infection as the provider had not replaced the mattresses even though they had been identified as a risk.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated Activities) Regulations.

People could not be assured that there were enough staff on duty who understood their needs or who had the skills and competencies to care for them safely. There had been a number of changes within the staff team and some staff who were familiar with the home and the needs of people living there were no longer working in the home. This impacted on the stability and continuity of the staffing arrangements in place. There was a reliance on the use of agency staff and due to the absence of a clinical or mental health lead staff were not receiving the guidance and direction required to fulfil their role safely.

People told us that they did not know all the staff that provided their care. One person told us "I am fed up of the constant change in staff." Staff told us that there was not enough permanent staff to provide the care and the service was using agency staff for half of the shifts.

At the time of our inspection there were a number of people in the home who had complex mental health needs, some of whom required one to one care. However none of the staff had the awareness and understanding required to safely and appropriately monitor risk factors associated with their mental health needs. This had resulted in people's behaviours not being adequately monitored and a lack of coordination with community mental health teams. This was considered to be exposing some people living in the home to risk of deterioration and or harm.

The consultants working for the provider, tried to book the same agency staff so that people had continuity of care, but the registered manager did not provide the rota far enough in advance to always achieve this. They also recognised that there was a lack of staff with the appropriate skills to provide for people's mental health needs and planned to recruit staff for all areas of the home including a clinical lead and staff with a skill mix that would provide for people's mental health needs. However at the time of our inspection we considered that the staffing arrangements in place were not safe.

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

Inadequate

Is the service safe?

People could not be assured that the recruitment processes had protected them from staff that did not have the skills, experience or good character to provide safe care. Not all staff had undergone checks with the Disclosure and Barring Service (DBS) in relation to their employment at the service. Not all staff had recruitment records that demonstrated their suitability to provide care. Some care staff had been employed through an agency that brought staff from other countries in Europe to England. Staff told us that they had undergone interviews and checks, but the registered manager had not kept records of these.

The consultants understood their role in providing a safe recruitment process and were in the process of planning how they were going to update the existing staff files to comply with the regulations.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (regulated Activities) Regulations.

People's risks were not being reviewed and plans to mitigate the risks were not recorded or embedded into practice. People were assessed for potential risks to their safety such as risks associated with moving and handling, falls and skin integrity. However we observed that identified risks were not always monitored on a regular basis and the reliance on verbal updates for staff exposed people to the risk of not receiving safe or consistent care.

Care records did not provide staff with the guidance on action to take to manage individual risk factors and care was not always provided in a way which minimised risk. For example staff told us about the measures they took to minimise risks of acquiring pressure ulcers by changing people's position every two hours, however this was not consistently seen in practice. We observed that not all the people who had been identified as high risk of acquiring pressure ulcers had been moved position every two hours

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

During our initial visit on 25 August 2015 we were concerned that staff did not have the information or access to the means to make a safeguarding alert in line with the provider's safeguarding policy. We advised the registered manager of our concerns, and when we inspected in October 2015 we saw that staff had access to the safeguarding information and equipment they need to raise a safeguarding alert. People could raise any concerns about their safety directly with staff and were confident that they would be responded to appropriately. One person told us "staff resolve things quickly, I feel safe."

Staff had received training in safeguarding of vulnerable adults; they demonstrated an understanding of the signs they would look for, and explained the action they would take if they thought someone was at risk of harm. The findings of this inspection and outside agencies raised our concerns that people had lost weight, medicines management was poor, people did not have their behaviours monitored and people were not referred to health professionals in a timely way. There had been 11 safeguarding alerts raised by outside agencies in relation to the poor care in August and September 2015, however, staff had not recognised when people had been at risk of harm and none of the staff had actually raised any safeguarding alerts.

During our initial visit on 25 August 2015 we were concerned that staff did not adhere to the policies and procedures for the management of medicines. We shared our concerns with the registered manager. A safeguarding alert had been raised by an outside agency which had prompted the NHS pharmacy team to audit the medicines the same week and help change staff practices. We found that many changes in practice had been implemented by our second visit on 7 October 2015, where staff demonstrated their understanding of the management of medicines.

On 7 October 2015 we found people received their medicines in a way they preferred. There were appropriate arrangements in place for the management of medicines. Staff had received training in the safe administration, storage and disposal of medicines. We observed staff administering medicines to people and heard them explain what the medicines were for. Where people received covert medicines they had had a best interest meeting and their GP had confirmed that it was in their best interest to take their medicines regularly in food or fluids. Guidance had been sought from the dispensing pharmacist about the types of food that were suitable for the covert medicines. Where people were on medicines that required them to avoid certain foods, staff had liaised with the kitchen staff

Inadequate

Is the service safe?

to ensure that they were aware of foods that were to be avoided. Staff followed guidelines for medicines that were only given at times when they were needed for example Paracetamol for when people were in pain.

Inadequate

Is the service effective?

Our findings

People were at risk of receiving care from staff that had not received adequate training to carry out their role to meet people's needs.

People told us that they did not have confidence in the abilities of all the staff that provided their care. One person told us "the staff pretty much don't know what they are doing, what training have they had? There are only three original staff left from two years ago." Another person expressed their concern about the skills and abilities of staff. They said "They [the agency nurse] didn't seem to know what they were doing" when they carried out a procedure. They also expressed their concern about care staff "They don't know how to change my [catheter] bag." They referred to the staff not being able to read English " I have to tell them how to do it because they cannot read the instructions." Staff told us they learnt how to provide the care from other staff, and there was no formal training for the care of urinary catheters.

The induction and training programs within the home had been impacted upon by the level of staff movement and the reliance on agency staff meant that not all staff had received the level of training required to safely or appropriately meet people's needs. The consultants working with the provider recognised the lack of staff skills and competencies and had begun to address this.

They were also in the process of developing an induction program whereby they planned for new staff to complete their induction training by shadowing more experienced staff before being able to work unsupervised. This process had not been formalised, it was in its infancy and had not yet been embedded.

Staff had recently received training in managing challenging behaviours. The training had been initiated by the consultants managing the home as they had recognised that staff were caring for people with complex mental health needs, without any training. The records showed that some staff had undergone training such as fire, infection control and manual handling via computer based learning. However most of the subjects were covered in one day and there was no evidence that this knowledge had been tested and staff competencies had not been proven.

People were cared for by staff who had not received adequate supervision to carry out their roles. Staff told us that they had not felt supported by the manager as they had not had regular meetings or had the opportunity to bring up any concerns. The consultant had commenced a programme of supervision which some care staff had received, however, the nursing staff had not received any supervision and the process had not been embedded. Staff did not receive adequate supervision to carry out their roles.

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

People had not always been properly assessed for their suitability to live at the home. One person received one to one care for the management of their challenging behaviours; they were also prescribed a combination of medications to help to reduce the frequency of their behaviours. When the person was admitted to the home from a hospital, the manager had been instructed to refer them to the local community mental health team to oversee their care and had also been asked to monitor and record the person's behaviours. There had been no monitoring of their behaviours or referral to the local community mental health team. The commissioners subsequently assessed this person and found that they had been placed in an unsuitable placement as the provider did not have the knowledge and staff skills to meet their needs, the commissioners were in the process of moving them to another placement.

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

Staff did not always provide food in a way that helped people maintain their weight. For example one person had been assessed as requiring food that was pureed due to swallowing difficulties. The person told us that until recently the staff had regularly provided them with sandwiches, even though they had told them many times that they could not eat them. We observed them asking staff for a custard pudding such as a crème brûlée as they thought they could manage this. The home did not have permanent kitchen staff, the care staff providing the meals did not know what a crème brûlée was, or how to make a custard pudding.

Inadequate

Is the service effective?

People who were on a specific fluid regime for their medical needs did not receive the support and guidance from staff to maintain their regime. For example one person had been advised by their doctor that they should only have one litre of fluid a day to maintain their health. We found that they were receiving in excess of this on a daily basis. The consultant told us that as this person had capacity they could choose to ignore the medical advice, however, when we spoke with the person they were unsure. They told us "I was on restricted fluid but now staff just give me the drinks whenever I want them, I'm not sure it still applies".

People with dementia were not helped to recognise that it was lunchtime as people did not move to the dining area to eat their meals. We observed that people remained in their armchairs in the lounge area and their meals were brought to them. Two people who were living with a dementia did not eat anything, and their records showed that one of them was losing weight. Staff were not providing a suitable environment for dining to promote people to eat and drink.

People received assistance from staff to eat their meals, for example staff helped to cut up their food. We saw that staff encouraged people to eat and provided alternative foods such as soup where people did not eat their meals.

People's risk of not eating and drinking enough to maintain their health and wellbeing was calculated by staff through the use of a Malnutrition Universal Screening Tool (MUST). We found that where people had lost weight staff had not recognised this as a risk to people's health as they had not calculated the MUST assessment accurately. In August we found that two people had not been referred to their GP or dietitian even though they had both lost over 5Kg. Another person had lost over 14Kg before staff had referred them to their GP for loss of weight. Although the consultants were in the process of assessing all the people at the home we still found that not all the MUST assessments were accurate or updated. People were at risk of malnutrition as staff did not carry out accurate risk assessments or refer people to health professionals in a timely way.

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

People had access to their GP every week. The staff provided a list of people that needed to be seen and staff followed the instructions given by the GP. People had recently been referred to the dietitian where staff had identified that they had lost weight. We saw that the dietitian had requested information such as daily food charts and these had been supplied.

Most people living at The Red House had a rash. Staff had alerted the GP, and staff had followed the GP's instructions. Two people had been assisted to attend a dermatology clinic to help diagnose the rash. People continued to be given the prescribed treatment for an undiagnosed rash, however, neither the staff nor GP had notified the local health protection team of the outbreak. We notified the clinical commissioning group who will take this forward with the relevant authorities.

People were assisted to attend healthcare appointments at hospitals and clinics. However, the information in the diary was not always clear as we found instructions for out-patient appointments but they did not include the person's name. Some appointments indicated that people would require an escort, there was no evidence that this provision would be made in the rota. The consultant assured us that this would be brought to the attention of the provider to ensure that staff escorts would be available for future healthcare appointments.

During our visit on 25 August 2015 we found that staff did not recognise that the care they were providing was depriving people of their liberty. Three people were under constant supervision and subject to staff depriving them of their freedom to mobilise freely. Two of these people had not been assessed in relation to Deprivation of Liberty Safeguards (DoLS). Neither the manager nor nursing staff had enough knowledge of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and DoLS regulations to recognise that the care they were providing was depriving people of their liberty. Since the employment of the consultants, everyone had undergone mental capacity assessments to determine their mental capacity to make decisions about their care. Where people did not have the mental capacity to make decisions; they had a best interest meeting with their next of kin and GP to plan the care they required. Some people required a deprivation of their liberty in their best interest. The consultants had applied to the relevant authorities for a DoLS application. People were now protected from the risks associated with their lack of mental capacity to make decisions about their care.

Requires improvement

Is the service caring?

Our findings

People told us that there were new faces every day. When we spoke with one person we observed a member of staff entering the room to provide a drink, they did not introduce themselves and did not have a name badge on, the person said "I don't know him". The member of staff put the drink on their table and left.

People's relationship with permanent staff was variable. Some of the staff did not speak English as a first language which people told us caused difficulties in making themselves understood. One person had bought themselves a Romanian translation book in order that they could communicate with staff, but they told us "I keep forgetting the words I look up." Another person told us "I ask the [staff] to draw the curtains, but they don't know what I mean".

Some people had a very good relationship with staff, one person told us "Staff are lovely, they're as good as gold. They get me nice clean clothes and I have lovely dinners, what more do I need?" We observed one member of staff kneeling down so they were at eye level and asking "Are you OK [name of person]? Your hair looks lovely", we saw the person respond with a smile. Another member of staff was seen talking to a person about their hobbies and read their book to them. However, most of the therapeutic engagement came from the consultancy staff who communicated effectively with people. Not all staff initiated conversations or involved people in what was going on. We observed some staff standing and watching and only respond when they needed to.

Where people were not able to communicate verbally we saw that staff did not try to engage with them. We found that one person who could not communicate verbally came alive when we spoke with them, they smiled and became animated. People who relied on staff to provide personal interaction were not receiving this.

We observed examples of care that was provided in a kind and compassionate way. People told us that staff maintained their dignity. Staff told us that some people preferred female carers and this was respected. They described how they would close the bedroom door when providing personal care and keep people covered when supporting them to have a wash. One member of staff told us "When dressing people we give them choices even if they cannot verbalise." Staff told us that they always ask for people's consent before providing care, which we also observed.

Staff were quick to respond when people showed they were distressed. One person displayed that they were worried, we heard staff provide reassurance "You're alright, you don't need to worry" and led them to a different area of the home.

Staff did not know the significance of people's interests and how this could affect their behaviours. For example staff knew that one person liked their music, especially if they were agitated, but they did not know what the music was or how this was relevant to the person and their past.

People were not always helped to maintain relationships with their families. One person relied on the internet and their mobile phone to maintain contact with their family. They had been assured that the home had Wi-Fi when they were admitted. Unfortunately they had found that the room they were in did not have a mobile phone signal or Wi-Fi and the home did not provide a landline. They were not able to maintain their independence or contact their family as they did not have the technology to do so.

There was not always the recognition from staff that people required help to maintain their hobbies and interests. One person had read and re-read all of their books and told us they were desperate for some new ones. However, none of the staff had helped them to obtain new books.

People's belongings were not always cared for or respected. People told us that they had lost items of clothing when they went to be washed. One person described how they were always cold and relied on their woolly socks and shawls, but these had been lost in the laundry. They also described how all of their white clothes were now a shade of grey. We observed the laundry area and found that all the 'white' clothing was a shade of grey.

The noise level in the home was unpleasant due to the constant sound of the alarms on bedroom doors from the fire door closing devices. This had an effect on people in their rooms and in the corridor as they had no respite from the noise. We observed that one person paced up and down the corridor getting increasingly agitated. When we brought this to the attention of the staff and the consultant,

Requires improvement

Is the service caring?

they all told us that they had not noticed the noise and could not tell us how long this had been going on for. The maintenance staff replaced the batteries whilst we were there and the alarms stopped.

Requires improvement

Is the service responsive?

Our findings

People's experiences in making complaints differed. Some people felt confident they could raise any complaint with staff, one person said "If I had a complaint I would tell the carer and they would raise it with the manager, things get done quickly, I have confidence in the staff." Other people told us they had made complaints but no action had been taken, for example where they had complained about the poor laundry service, lack of promised internet access and their broken windows. Staff told us that they would report any verbal complaints to the nurse who tried to rectify people's complaints straight away. Information on how they were to rectify people's verbal complaints were shared during the verbal handover. There were no records of any of the verbal complaints that had been raised or the action that had been taken as a result. There had been one written complaint recorded, but this had not been responded to, investigated or used as learning to improve the service. The complaints policy stated that people would receive a response to their complaint within 28 days, but this had not happened. The policy could not be followed as it referred to people who no longer worked in the organisation such as a regional manager. People could not rely on staff responding to their complaints as staff did not adhere to their policy and the provider did not respond to people's complaints.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (regulated Activities) Regulations.

People received inconsistent care because the systems in place to assess their needs and to ensure that care was provided in line with their needs and preferences was fragmented and needed to be improved. Although a range of assessments had been completed these had not consistently been used to formulate a plan of care which would guide staff in how to safely meet these needs. Some staff were familiar with peoples care needs and preferences however other staff did not have these insights and the impact of poor care planning documentation was noted in their practice.

Some people living in the home had been assessed as being at risk of falls and others were at risk of acquiring pressure ulcers. However there were no care plans in place to guide staff in how to support these individuals and as over half of the staff were agency staff the care that we observed was not always in line with appropriate practice. Although staff had received a verbal handover about using pressure relieving equipment such as air mattresses and moving people regularly to relieve their pressure areas, the care was not consistent. We observed that people had sat in one position for many hours without being helped to relieve their pressure areas. Records showed that where people required turning every two hours that this was not always achieved. In addition some staff did not know what type of sling people required when using the hoist and this was not detailed within their care plans.

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

Staff received a verbal handover which provided nearly all of the care requirements of people. However, the verbal information was not comprehensive enough to describe the care that people required for the agency staff who were new to the service.

The consultants working with the provider had begun the process of reviewing everyone's assessments and their care plans and people told us they had been involved in this process and we saw that there were plans in place to begin to involve the relatives in the care planning. However, these plans were in their infancy, and staff did not yet have access to the newly developed care plans.

Families helped to provide information about peoples' past lives and what types of activities they enjoyed. Some staff were aware of people's interests and ensured that people could pursue these such as watching television or doing jigsaws. However, people's interests did not form an integral part of their care planning and were not always incorporated into their daily living. We observed that not all staff readily engaged or interacted with people unless they were providing care. There was no planned activity or any one member of staff responsible for ensuring that people could have the opportunity to take part in something that interested them.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post, however due to understandable circumstances they had been repeatedly absent from the home over the last few months. Since our inspection in February 2015 the interim manager had left at short notice and the registered manager had not found a suitable replacement. Established and experienced nursing staff had also left and had not been replaced, leaving only two permanent nursing staff to manage the service. The lack of consistent managerial and clinical leadership and oversight had impacted on the quality and safety of the care being provided. In addition the lack of a contingency planning was a concern.

People living in the home described the situation as "very bad, this place lurches from crisis to crisis, there seems to be no-one in charge." One person referred to the lack of management at the home, they summarised with "there's trouble up top." During the registered manager's absences they had locked the office, which meant that staff did not have access to information about the running of the service and equipment such as the computer, photocopier, printer and fax machine. Staff were not able to carry out any administrative tasks, such raising safeguarding alerts, notifications, or checks for the equipment, fire safety and health and safety.

People relied on staff to listen to their concerns and provide for their needs. Staff had provided care that was within their knowledge and experience. They had put people first; they responded to their concerns and took action to remedy any situations that arose, they had worked extra shifts to ensure people had received care. However this dedication had not been supported by robust management systems or staff in place to provide direction and guidance. This had led to situations such as people losing weight without being referred to health professionals in a timely way; people with complex mental health needs had not been suitably monitored or reviewed by the community health teams. People had not received safe care as the registered manager had not ensured that staff had the knowledge, skills and management support to carry out their roles and meet peoples' needs.

We raised our concerns about the lack of management with the registered manager on 25 August 2015; they immediately appointed a consultancy firm to oversee and manage the service. On 7 October 2015 we found the service continued to be managed by the consultants with the registered manager providing input via the telephone on a daily basis. However the registered manager had not equipped the consultants with all the means to manage the service effectively as the manager had retained the role of providing the rota and the management of the finances. The consultants did not have enough management control to ensure that urgent repairs were carried out, or that the staff had been allocated on the rota far enough in advance to ensure continuity of care. We could see that the consultancy company had identified areas where improvements were needed and they had begun to prioritise the action that was required. However we continued to identify areas where care was not being delivered in a safe or consistent way.

People could not be assured that they lived in a safe environment as the registered manager had not made provision for repairs. Safety audits had been carried out and these had identified areas of the home that required repair such as the windows, window restrictors and fire door on the first floor and replacement of soiled mattresses; however these serious risks had not been addressed. The consultants relied on the registered manager to provide funding for the repairs identified in these audits however this had not been forthcoming. There was no system in place to ensure on-going maintenance of the home.

People did not always receive their correspondence. The registered manager did not ensure that correspondence was responded to in a timely way. On 25 August 2015 we found that there was two weeks' worth of un-opened post addressed to the home and to the people who used the service. On 7 October 2015 we saw that the post again remained unopened for over two weeks, on this occasion the consultants had ensured that correspondence addressed to people had been distributed. There was a risk that people would not receive their healthcare appointments or care advice from health professionals as post containing this information may not be opened.

Records relating to all areas of the business were in chaos. The consultants had begun the process of creating comprehensive information about the people who used the service. They had completed their assessments and were planning to involve relatives in the care planning, but the care plans were not in use and had not been shared with staff as yet. Records about people were not complete

Inadequate

Is the service well-led?

and were still in the stages of development. We observed that staff were reliant on verbal handovers and their own awareness of people's care and support needs and as over half of the staff team were agency staff this was exposing people to unnecessary risks.

People could not be confident that records relating to recruitment of staff were robust. The paperwork relating to staff was chaotic, the information relating to staff, their recruitment and training were in piles of mixed paperwork. Where there were staff files, some of them no longer worked for the service. The consultants could not find information relating to all the staff therefore vital information relating to the recruitment process was missing. People were at risk of being cared for by people who had not undergone the appropriate checks as the records were not able to demonstrate that the registered manager had carried these out.

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

There was no system in place to ensure people's belongings were respected and well cared for. We found peoples valuables stored in medicines cabinet including a cheque from the premium bonds for one person. There were items of sentimental and monetary value being kept in the medicines cabinet for people who were no longer using the service. There was no evidence that the registered manager had taken any steps to reunite these items with people or their families.

There was no clear leadership at the home. People did not know who the manager was, one person thought it might be the nurse. One member of staff had received supervision from someone from the consultancy firm, but they could not tell us the name of the person and said "I don't know their position in the company".

The consultants had held a service user and relatives meeting and a staff meeting. Relatives told us that this had been useful in allaying their concerns and they believed that the service was improving. Staff told us "The meetings had been very constructive, as we were having an input into the changes and developing the service." Staff said they felt they were being listened to, they described the consultants as pro-active and very approachable.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People had not always been properly assessed for their suitability to live at the home. Regulation 12 (2a) People received inconsistent care because the systems in place to assess their needs and to ensure that care was provided in line with their needs and preferences were fragmented. Regulation 12 (2a and b) People's risks were not being reviewed and plans to mitigate the risks were not recorded or embedded. Regulation 12 (2a and b) The provider had failed to ensure that the home was maintained in a condition which protected the health and safety of people living in the home. Regulation12 (2d)

The enforcement action we took:
We have commenced the process of cancelling the registration of the provider and Registered Manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were at risk of malnutrition as staff did not carry out accurate risk assessments or refer people to health professionals in a timely way. Staff did not follow medical advice for fluid regimes. Staff did not provide an environment that would promote eating or provide foods that were suitable for people's needs. Regulation 14 (4d)

The enforcement action we took:
We have commenced the process of cancelling the registration of the provider and Registered Manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Enforcement actions

People were at risk of infections as the mattresses were not clean. Regulation 15 (1a and 2)

The enforcement action we took:
We have commenced the process of cancelling the registration of the provider and Registered Manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints People could not rely on staff responding to their complaints as staff did not adhere to their policy and the provider did not respond to people's complaints. Regulation16 (1 and 2)

The enforcement action we took:
We have commenced the process of cancelling the registration of the provider and Registered Manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were at risk of being cared for by people who had not undergone the appropriate checks as the records were not able to demonstrate that the registered manager had carried these out. Regulation 17 (2di) There is a lack of consistent managerial and clinical leadership and oversight of the quality and safety of the care being provided. There is a lack of a contingency planning. The registered manager had not ensured that staff had the knowledge, skills and management support to carry out their roles and meet peoples' needs. There was no system in place to ensure on-going maintenance of the home. People did not always receive their correspondence. Records relating to all areas of the business were in chaos. Regulation 17 (2dii)

The enforcement action we took:
We have commenced the process of cancelling the registration of the provider and Registered Manager

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a lack of stability and continuity of the staffing arrangements, and a lack of staff with the appropriate skills to provide for people's mental health needs. Regulations.18 (1) People were at risk of receiving care from staff that had not received adequate training or supervision to carry out their role to meet people's needs. Regulation 18 (2a)

The enforcement action we took:
We have commenced the process of cancelling the registration of the provider and Registered Manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Not all staff had undergone checks with the Disclosure and Barring Service (DBS) in relation to their employment at the service. Not all staff had recruitment records that demonstrated their suitability to provide care. Regulation 19 (1a and b) and 19 (3a)

The enforcement action we took:
We have commenced the process of cancelling the registration of the provider and Registered Manager