Leonard Cheshire Disability

St Anthony's - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected this service on 14 June 2017 and it was an unannounced inspection. Our last comprehensive inspection took place in September 2016. We found that actions were required to improve the care of people. At this inspection we found insufficient improvements had been made which included the way risks to people including behaviours and medicines were managed, how people were protected from potential abuse and when concerns were reported externally. Improvements were also needed to ensure people were supported with capacity and consent and ensuring effective systems were in place to identify when improvements within the service were required. The provider sent us a report in December 2016 explaining the actions they would take to improve. At this inspection, we found that the necessary improvements had not been made.

The service was registered to provide nursing support for up to 34 people with physical disabilities. At the time of our inspection 31 people were using the service.

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

Risks to people were not always managed in a safe way. When people displayed behaviours that may challenge we could not be sure the behaviour management plans and staff understanding that were in place would be effective in reducing the risks to the person. We could not be assured the provider understood when people were at risk. There were no environmental risk assessments in place in relation to a recent flood that occurred within the home. Staff were unable to demonstrate understanding of the fire procedures within the home.

When people needed as required medicines in an emergency situation staff were unable to access this in a timely manner. Guidance for as required medicines was not always in place for staff to follow. Staff demonstrated an understanding of safeguarding however some incidents and accidents had not been reported as required. Staff were available in communal areas however people and relatives felt they had to wait for support when they pressed the call alarm.

Complaints were not always recognised and responded to in line with the provider's policy. Information recorded in people's care files did not always match the care they received. Health professionals felt that the home lacked leadership. When employment checks had been completed the provider had not assured staffs suitability to work within the home. Some of the audits that were introduced were not always effective in identifying concerns or areas of improvement.

When people lacked capacity to make decisions for themselves we saw capacity assessments were sometimes unclear. When people were being restricted unlawfully this had not always been considered by

the provider. We could not be assured the provider was working with in the principles of MCA or fully understood this.

Staff received training however we could be assured their knowledge in these areas was checked. People did not always receive support from health professionals in a timely manner. We could not be sure staff always understood how to support people, to make choices

People enjoyed the food and were offered a choice; they were able to participate in activities they enjoyed. Staff felt supported and were given the opportunity to raise concerns. Equipment was maintained and tested to ensure it was safe to use. People and relatives were happy with the staff. Relatives and visitors were free to visit anytime and felt welcomed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
When people displayed behaviours that may challenge we could not be sure the behaviour management plans and staff understanding that were in place would be effective in reducing the risks to the person. Environmental risk assessments were not in place as needed. Staff were unable to demonstrate the fire procedure within the home. We could not be assured people received medicines for epilepsy as promptly as required. As some incidents had not been investigated or considered as safeguarding concerns we could not be sure people were protected from potential abuse. The provider had not fully considered people's suitability to work within the home. Staffing levels had increased however people and relative still felt they had to sometimes wait for support.

Is the service effective?

Inadequate

The service was not effective.
People's capacity assessments were not clear. When people were being unlawfully restricted this had not always been considered. Staff received training however we could be assured their knowledge in these areas were checked. People did not always receive support from health professionals in a timely manner. People enjoyed the food and were offered choices at mealtimes.

Is the service caring?

Requires Improvement

The service was not always caring.
We could not be sure staff always understood how to support people, to make choices. People and relatives were happy with the staff. Relatives and visitors were free to visit anytime and felt welcomed.

Is the service responsive?

Requires Improvement

The service was not responsive.
People's needs were not always responded to and when concerns were identified actions were not always linked together. Information in people's care plans did not always match the information staff told us. We could not be assured

when complaints had been made they were fully understood and responded to in line with the procedures in place. Staff had lack of understating about people's diversity and human rights. People were given the opportunity to participate in activities they enjoyed.

Is the service well-led?

Inadequate

The service was not well led.
Concerns have been identified about the provider and whether they can make and sustain improvements. The provider remained in breach of regulations and have not made the necessary improvements needed to comply. There were concerns with the management of the home and the lack of leadership. Not all of the audits introduced were effective in highlighting concerns or making improvements. The provider was not conspicuously displaying their rating in line with our requirements. Staff felt listened to and had the opportunity to raise concerns.

St Anthony's - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection visit took place on the 14 June 2017 and was unannounced. The inspection visit was carried out by two inspectors and a pharmacy inspector. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information of concern we had received from the public and health care professionals. We used this to formulate our inspection plan.

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

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with three people who used the service, three relatives, and three members of care staff. We also spoke with two registered nurses, a senior member of care staff, the deputy manager and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met. A service manager from another home provided support to the registered manager during the inspection visit.

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

Inadequate

Is the service safe?

Our findings

At last our comprehensive inspection, we found that risks to people had not been fully considered. When people behaved in a way that may cause harm to themselves or others the actions that were put in place were not always effective to reduce the risks. This was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.The service was previously rated as requires improvement in this area. At this inspection we found the necessary improvements had not been made.

At our last inspection we raised concerns with how behaviours were managed. At this inspection we found that when people had behaviours that may challenge the actions that were put in place were not always effective. For example, we looked at records for one person. It was identified that this person may continually press the call bell. This was seen by the home as a 'challenging behaviour'. There was a care plan identifying what action staff should take when the call bell was pressed. This included 'If they continue to use it, can leave it ringing for longer than 15 minutes'. This care plan did not take into consideration all of the person's needs which were detailed in further plan. For example, in one care plan it was documented 'Ask [person] to ring the call bell if they are getting themselves into their wheelchair'. This care plan showed the person was encouraged to use the call bell when support was needed. It was also recorded, 'I don't always remember why I rang the call bell'. We spoke with staff who gave us different views about how to support this person. One staff member said, "The deputy goes to the meetings". Another staff member told us, "We just turn the bell off; I think the person has mental health issues" After the inspection we spoke with a healthcare professional who raised concerns about how behaviours in the home were managed. They told us they had worked with the home to put strategies in place to support this person however they had not been made aware of the plan which had been put in place to leave the person's call bell ringing. Therefore the plan they had put in place may actually put the person at more risk because staff are encouraged not to respond to them. We looked at records for other people and saw when guidance was in place to manager behaviours it lacked detail, including possible triggers and action to take.

Staff did not have a good understanding of how to support people to manage risk and the provider had not ensured adequate risk assessments were in place. At our last two inspections we observed that one person wore a call bell around their neck placing the person at risk. There were no risk assessments in place for this person and the person did not have the physical dexterity to use this alarm. We had raised concerns because we felt that it was a choking risk and it was not serving a purpose to the person. The manager told us at the last inspection that it was there for the family to use when they visited. We asked them to review this situation and to consider all of the risks to the person. During this inspection we observed a staff member supported this person into the communal lounge. Even though there were staff present in this area and safety checks were completed, the staff member placed a call alarm in the person's hand. We spoke with the staff member who told us, "We always give [person] the buzzer when they come in here. I don't know why. They have limited mobility so they can't use it. I would always do this; it's what I was told to do". Another staff member told us the person no longer used the call bell. There were no records in place in relation to this. We spoke with the registered manager who told us the person no longer had an alarm. This meant we could not be sure that staff understood when people were at risk or that this information had been effectively shared with staff.

We saw when there were risks to the environment these had not been fully considered. For example, a recent flood had occurred within the home. This had resulted in some of the carpets being removed and the floor was uneven with a hard surface. People who live at St Anthony's have reduced mobility and use wheelchairs. We asked to see the risk assessments in relation to this and other aspects of the flood. For example, there was a room open with piping in that was drying out and the home had been using equipment to dry out the building. The registered manager told us there were no risk assessments completed in relation to the flood. They said, "There are no risk assessments, we haven't needed them as there are no risks". They had not considered the changes to the environment created new risks to people's safety.

Furthermore we saw that a fire exit was blocked. The fire door had been opened and a portable barrier placed in front of the door. We spoke with the registered manager who told us it was to stop people leaving the building. . There were no risk assessments in relation to this. Staff were unable to demonstrate an understanding of fire procedures. One staff member said, "If there is a fire we are told to wait for orders from the team leader or the staff member who is leading that day". Another staff member said, "I would leave the residents where they are and go up to the office". Both were unable to explain the fire evacuation procedure. This meant we could not be assured that fire regulations were met because the environment was not managed safely and staff may not take appropriate action if a fire occurred within the home.

We saw that some people were prescribed as required medicines for management of epilepsy. Staff we spoke with and records confirmed, these were life threatening conditions. We looked at protocols for these medicines and we saw this needed to be administered for some people after four minutes of being in a seizure. We saw this medicine was stored in a separate locked cupboard and when we requested staff to open this cupboard there was confusion as to what key opened this. It took five minutes for the key to be located. This meant there was a risk of people having seizures and not receiving their medicines as promptly as required to prevent the seizures becoming life threatening.

Some people living in the home were receiving medicines on an 'as and when required' basis; also known as PRN. For some people there was no information, known as PRN protocols, in place to help staff identify when a person may need the medicine or the frequency and maximum dosage that people could safely receive over a 24 hour period. We spoke with the registered manager about this who told us, "The nurses would follow the BNF". The British National Formulary (BNF) is a pharmaceutical reference book. We checked the provider's medicine policy which confirmed that guidance should be written for each individual's PRN medicines for staff to follow. This meant that there were no control measures in place to ensure these medicines were used appropriately.

When people were prescribed pain relief in the form of weekly patches that were placed upon their skin. There was no documentation in place to ensure the patch was removed and rotated to ensure this was administered as prescribed. This meant we could not be sure people received this medicine as prescribed.

We also observed during a medicines round that a nurse used her hands to split a tablet in half. The staff member then administered the medicines to the person and the other half of the tablet was put back in the jar with the remaining tablets. This meant that we could not be assured of the integrity of the medicine.

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

There were procedures in place and staff demonstrated an understanding of safeguarding. However when we looked at incident and accident records we saw some incidents had not been reported to the local

authority as the lead agency for investigating safeguarding concerns. For example, we saw an altercation had taken place between two people where one had 'punched someone three times'. We spoke to the deputy manager who confirmed this had not been considered as a potential safeguarding concern. Furthermore we saw records where unexplained bruising had been observed and an injury had occurred to another person. The deputy manager was unable to confirm if an investigation into how these had occurred had taken place. They did confirm they were unexplained and had not been considered as potential safeguarding concerns. They told us they would check and update us; however we have not received any information in relation to these. This meant we could be sure people were protected from potential abuse.

This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The provider had not fully considered people's suitability to work within the home. The provider used volunteers and when they were under the age of 18 we were told by a staff member that they could not have a DBS check completed. The disclosure and barring service (DBS) is a national agency that holds information about criminal convictions. Due to this the staff member told us the volunteer could not work unsupervised. We asked to see risk assessments for these people but we were told that they had not been completed .The relevant DBS checks were in place for staff who had employment contracts with the home.

Since our last inspection staffing levels had increased by three care staff on the morning shift. We saw there were staff available for people in communal areas. However people and relatives said further improvements were needed. One person when asked acknowledged they had to wait for support and did not feel there were enough staff. A relative told us, "Staffing is still an on going issue, they need some more. Now they come in and turn the buzzer off so it doesn't show on the records. They say someone will come in a minute then its 20 -30 minutes later". A person confirmed there buzzer was turned off and then they would have to wait further. We looked at a monthly audit of the call bell monitoring form. In May 2017 200 bells were recorded as ringing for over 15 minutes. The register manager who had completed this had identified the shortfalls with staffing. They had documented, 'The main bulk of call bells are in the evening when less staff are on duty and they are busy'. This meant we could not be sure people's call bells were answered in a timely manner.

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection on 23 September 2016, we found when people were unable to consent, capacity assessments and best interest decisions were not always clear. This was a continued breach of Regulation 11 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found the necessary improvements had not been made.

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

Staff and the registered manager did not demonstrate an understanding of the MCA. We discussed with the registered manager changes they had made since the last inspection. They told us they had revisited all areas of capacity for people. They said, "We had highlighted boxes that we had ticked wrong, so we have started again and ticked the right ones". We were also told one person's capacity assessment had not been completed due to behaviours they were currently displaying. The registered manager told us, "We cannot sit down with this person to test them". This demonstrated the process of assessing people's mental capacity was not understood. When asked about people's mental capacity, one staff member said, "Off the top of my head I don't know about that". We saw an audit had been completed by the area manager in June 2017 which had identified concerns with staff knowledge in relation to mental capacity. Furthermore for three people who at the last inspection we highlighted concerns with their capacity assessments, no review or action had taken place. The registered manager told us this was because capacity assessments were reviewed every 12 months.

It was unclear if people lacked capacity to make decisions for themselves. For example, the registered manager told us that one person had capacity. We spoke with staff about this person who stated they would only have capacity in some areas. When we looked at records for this person they said, '[person] will not always tell you when they are in pain' and '[person] has long term memory loss of events and is only able to make day to day choices'. We further discussed this with the registered manager who told us that for this person they could make decisions at certain times of the day when they were less tired. There were no capacity assessments in place reflecting this. We saw documented through other people's files that relatives made decision on people's behalf. We did not see any evidence that this had been completed in people's best interests.

When restrictions had been placed upon people these had not been considered. For example since the last inspection we saw some people were using specialist equipment including bed and chair monitoring sensors. People had not consented to using these and when they were unable to consent there were no capacity assessments or best interest decisions in place in relation to this equipment. We asked the

registered manager if DoLS referrals had been made in relation to this equipment. They confirmed they had not completed this but advised us they were going to discuss this when the person was reviewed. However, we saw for one of the people using this equipment a DoLS referral had been made the day before the inspection visit and this had not been considered. The registered manager confirmed to us they had not seen this as a restrictive practice. We saw other restrictions had been placed upon people that had not been fully considered; this included, wheelchair straps on people's feet and people having limited access to their cigarettes. When DoLS referrals had been made to the local authority we did not see any guidance in place advising how people should be supported in the least restricted way while these were considered. This meant the principles of MCA were not followed.

This is a continued breach of Regulation 11 and 13 (5) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

Staff told us they received an induction and training however we could not be assured how people's knowledge was checked. For example, we saw records that training was completed by staff in both mental capacity and behaviour management. All the staff we spoke with did not demonstrate and understanding of mental capacity or how to consistently offer support around behaviours that may challenge. A health professional we spoke with confirmed there was a concern with staff competence within the home especially in relation to managing people's behaviours. We identified this concern at our last inspection and saw that no action had been taken to address it because competency assessments had not been implemented.

This is a breach of Regulation 18 (2) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

Information was not always easily available and so we could not be sure people received support from health professionals in a timely manner. It was identified that a referral to a specialist healthcare professionals was needed for a person. It was unclear if this referral had been made. The registered manager told us this was the responsibility of the social worker and GP. During the inspection the registered manager spoke with both the social worker and GP for this person requesting it was made. However we saw documented that this had been completed the day before our inspection and the registered manager was unaware of this. Furthermore appropriate referrals for people were not always made. We saw when one person was refusing food and steadily losing weight a referral was made to a dietician even though they were not assessed as meeting the risk rating for this to be necessary. It had not been considered this was symptomatic of concerns with the person's mental health. After the inspection we spoke with both professionals who confirmed they had requested the home to make the referral on behalf of the person. A health professional also told us this person had an appointment in relation to a health concern and confirm that this was missed by the home and they did not attend.

People told us they enjoyed the food and there were choices available. One person said, "The meals are always good". At breakfast and lunch time we saw people were offered choices. There were cold drinks available in the communal areas for people to access and hot drinks were offered to people at various times throughout the day. We saw that there were snacks available and there was a range of sandwiches in the fridges for people to access. When people had specialist diets such as soft diets we saw this was provided for them to ensure their needs were met.

Requires Improvement

Is the service caring?

Our findings

At our comprehensive inspection, we found people were not supported in a dignified way. This was a continued breach of Regulation 10 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found the necessary improvements had been made however other areas needed improvement.

At the last inspection we saw there was a clothing rail in the communal areas for people's missing clothes meaning people were not always supported in a dignified. At this inspection we saw this had been removed. We also saw a screen had been purchased and was used to cover the door when people were receiving physiotherapy, offering people privacy if needed. This meant people were supported in a more dignified way.

We saw further improvements were needed because when people could mobilise and verbally communicate we saw they could make choices about their day however for other people we did not see how choices were made. For example we saw people were brought into communal areas by staff, we did not see staff ask them where they would like to sit or what they would like to do. We spoke to one staff member who said, "They always sit there in front of the television I don't know if they want to I can't ask them". Some people had pictorial communication aids attached to the back of their wheelchairs, so they were transported around the building with the person. During our inspection we did not see staff use these aids with people to help them to make choices. We asked a staff member about these communications passports. They said, "I'm not sure what it is". This meant we could not be sure staff understood or supported people to make choices.

People and their relatives were happy with the staff. One person said, "I like the staff; they help me if I need them to. They are all friendly". A relative told us, "I can't fault the staff that are here". We saw staff offering people assistance and support. For example, we saw one staff member ask a person if they would like help to make their drink to which the person agreed.

Relatives we spoke with told us the staff were welcoming and they could visit anytime. One relative told us, "I am here quite a lot I can come whenever I like. The staff always say hello". We saw and staff confirmed that relatives and friends visited throughout the day.

Requires Improvement

Is the service responsive?

Our findings

People's needs were not always responded to. For example, one person told us they were experiencing back pain. They told us they previously used a mattress which had been taken from them to give to someone else. They felt since the mattress had been changed they had an increase in back pain. We spoke with the registered manger about this, they confirmed the mattress had been changed and others tried. They told us the rationale for this was, "Another person who was at higher risk (of developing pressure areas) needed it". We asked the registered manager to explain how it was decided who needed this equipment the most. The registered manager confirmed it was their decision and there was no rationale other than their risk was not high enough. It was documented in this person care file they were at risk of developing pressure damage. The registered manager was dismissive of the concerns raised by the person and said, "They are back on one of the mattresses they complained about before. They don't understand that the mattress they want won't help their back pain".

Furthermore during the inspection a relative raised concerns about as required medicines that had been prescribed for this persons back pain. When we looked at records we saw this medicine was being administered four times a day, since it had been prescribed over two month ago. We observed staff giving this medicine to the person before establishing if they wanted it or if they were in pain. The relative and ourselves intervened. When the person was asked if they were in pain and would like the medicines they declined and this was not administered. We looked at records for this person and a care plan in relation to medicines had been completed since the as required medicines was prescribed. There was no mention in the care plan of this medicine. We initially spoke with the registered manager about this who told us that they had been advised to keep the person's pain relief up to manage their pain. This had not been discussed with the person who had capacity to make this decision themselves. We also saw records for this person where a health test had been carried out this had identified some concerns with persons back. We did not see the registered manager home had reviewed the back pain or taken any further action as a consequence of this test.

For another person we saw it had been amended in their care plan that due to an issue with their wheelchair they were to have two hourly bed rest to offer pressure relief. We did not see any evidence that the person had been involved with this decision. During the inspection we saw this person was in the lounge at 09:30 and at 11:30 they went for bed rest. When we checked at 1630 the person remained in bed. We discussed this with the registered manager who told us, "If [person] doesn't give us the thumbs up or if they are asleep we don't get them up". There was no documentation in place to support this.

Staff had lack of understating about people's diversity and human rights and records confirmed they had not received training in this area. Cultural needs were not always considered. For example, it was documented that one person liked to speak in Punjabi and Hindu. For another person it was documented, I like to watch films in my own language. There was no evidence how the people were supported with this or if this occurred.

This is a breach of Regulation 9 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations

2014.

We could not be assured when complaints had been made they were fully understood and responded to in line with the procedures in place. We spoke with a relative and a person who both told us they had made a complaint. The person told us, "I have complained and complained about this". The relative said, "No one had listened to us when we complained". There was no record of this complaint. When we spoke with the registered manager they confirmed they had not fully investigated this. They said, "It wasn't a complaint they wanted to talk to me, they didn't say it was a complaint". The relative confirmed this had been on going since September 2016 and it had not been resolved. After we had intervened the registered manager said they would now investigate this as a complaint. The registered manager did not keep a record of concerns that were raised so we could not review if any further complaints had been made.

This is a breach of Regulation 16 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

People were given the opportunity to participate in activities they enjoyed. One person said, "I can join if I want". We saw activities taking place this included a game. There was information displayed in the communal areas about up and coming events people could participate in.

Inadequate

Is the service well-led?

Our findings

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

Since our first comprehensive inspection on 25 April 2016 there has continued to be breaches of Regulation 11, 12 and 13 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. Despite meeting with the registered manager and providers and three action plans we have found that the provider has not made the necessary improvements to comply with these regulations. We have continued to identify concerns with the management of the home and we found no action had been taken by the providers to address these. Furthermore when improvements have been made these are not sustained. For example at the inspection on the 25 April 2016 we identified concerns with responding to complaints, at the next comprehensive inspection in September we found improvements had been made. At this inspection we have again found concerns with recognising and responding to complaints.

In the action plan we received on 30 November 2016, the provider and registered manager gave us assurances they understood and could meet the legal requirements under the mental capacity act. The action plan stated, 'We are reviewing MCA's to ensure best interest decisions are made using clear capacity assessments.' We saw this action would be complete by 16 December 2016. At the inspection although we found mental capacity assessments were in place, we found they had not always been reviewed since last inspection, they were not individual and people's capacity had not been fully considered. Therefore we could not be assured the providers understood the requirements of the regulation to ensure they were compliant.

At previous inspections we raised concerns the service did not always offer person centred support. We observed when people were able to verbally communicate and consent they received a more person centred approach than people who could not. Records showed us that there was a focus on people's physical needs and less support was offered in relation to other needs people may have for example, emotional and spiritual. We saw improvements had not been sustained in this area. We spoke with a range of health professionals after the inspection who supported our concerns around the culture and management of the home. One health professional told us, "It's not professional, it's so poorly managed".

Since our last inspection we found quality monitoring and audits were being completed. This included monitoring of call bells and medicine management. However, we did not see how this information was used to drive improvements to the service. For example, we looked at the medicines audit it showed us there were concerns with missing signatures on medicines administration records. We saw this concern had been

identified and documented for at least three months. Although medicines error forms were completed by the staff member when this had occurred. The errors still continued to occur and there was no action in place to mitigate further occurrence. After the inspection we received an email from the head of clinical excellence for Leonard Cheshire Disability. They told us they had conducted a visit and 'was very concerned that there were a number of non-compliances identified in relation to medicines management'. During our inspection we were not told by the registered manager about these concerns or the action plan.

We looked at audits that had been completed by the provider in relation to compliance, following our previous inspections. We saw that the provider's quality team had completed a service visit which reviewed the service under the five domains that we use. However they did not use the findings from previous inspections to plan their review. For example, when they looked at the 'effective' domain they did not prioritise or make any recommendations related to the MCA and the continued breach of regulation 11 that we had identified. In the action plan we did not see anything in place to respond to the concerns we have previously identified through our reports.

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

The provider was displaying their rating, however this was not conspicuous as it was displayed in the corridor at the far end of the building. The report was displayed however the poster was at the back of the report and could not be seen. We raised this concern at our last inspection and no action had been taken.

Staff told us and the management team confirmed that supervisions and team meetings were taking place. One member of staff said, "Yes we have team meetings". Another staff member said, "I have the opportunity to raise concerns with the nurses or seniors".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not always responded to and when concerns were identified actions were not always linked together. Information in people's care plans did not always match the information staff told us. Staff had lack of understating about people's diversity and human rights.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity assessments were not clear. When people were being unlawfully restricted this had not always been considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment When people displayed behaviours that may challenge we could not be sure the behaviour management plans and staff understanding that were in place would be effective in reducing the risks to the person. Environmental risk assessments were not in place as needed. Staff were unable to demonstrate the fire procedure within the home. We could not be assured people received medicines for epilepsy as promptly as required.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment As some incidents had not been investigated or considered as safeguarding concerns we could not be sure people were protected from potential abuse. When people were being unlawfully restricted this had not always been considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We could not be assured when complaints had been made they were fully understood and responded to in line with the procedures in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Concerns have been identified about the provider and whether they can make and sustain improvements. The provider remained in breach of regulations and have not made the necessary improvements needed to comply. There were concerns with the management of the home and the lack of leadership. Not all of the audits introduced were effective in highlighting concerns or making improvements. The provider was not conspicuously displaying their rating in line with our requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff received training however we could be assured their knowledge in these areas were checked.