Care Quality Commission

Key Healthcare (Operations) Limited

Victoria House

Inspection report

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Ratings

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

Overall summary

We completed this unannounced inspection on 18 and 27 November. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

On 14 November 2014 the new registered manager's application to become a registered manager was approved by CQC. 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.

Victoria House is registered to provide nursing and residential care for 68 people and the service operates across four distinct units. Up until September 2014 the home had three units; one for people with a physical disability; one residential unit for people living with a dementia; and a nursing unit for people living with a

Summary of findings

dementia. In September 2014 the provider started using a fourth unit, which they named Regent House. The provider described this service, as a specialist unit for the rehabilitation of people with enduring mental health needs which was staffed with registered mental health nurses 8am to 8pm seven days a week.

At this inspection we found that there were breaches of 11 of the regulations relating to care from regulation 9 to 26, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Also there were breaches of regulation 18 of the Care Quality Commission (Registration) Regulation 2009. We had serious concerns about the service provided in the Regent House unit and took immediate action to reduce the risk posed to people using this unit. The people who used the Regent House unit moved out on 6 December 2014.

The concerns we had about the Regent House unit were that no nursing cover was provided and none of the staff had received any training in supporting people with mental health needs. No assessments had been completed and staff could not demonstrate that they could meet the needs of the people who had been admitted to Regent House. For five of the seven people who used this unit no care plans or risk assessments had been developed. We found that staff could not clearly detail the risks, whether people were subject to any legal constraints such as sections of the Mental Health Act or how they were supported.

We found that staff had not reported incidents of aggression or intimidation to the local authority safeguarding team nor had they dealt with complaints appropriately. On 27 November 2014 the registered manager collated and submitted information about all of the incidents to the local authority safeguarding team and notifications to us.

At times staff needed to physically intervene but had not received appropriate training to deal with any behaviour that challenged.

We did have concerns about the remaining provision at Victoria House. Parts of the home needed to be repaired; the residential unit was excessively hot and staff had not taken action to ensure people remained hydrated; staff were not adhering to the requirements of the Mental Capacity Act 2005; and staff were not using least restrictive practices.

We informed the provider of these concerns and received a comprehensive risk assessment identifying how these issues would be addressed on 8 December 2014. In the subsequent week the provider sent confirmation that action had been taken.

We found that the registered manager had some systems for monitoring and assessing the effectiveness of the home in place but others needed to be developed.

The provider's statement of purpose and service user guide did not provide clear information for people who used the service around what the purpose of each unit. The provider expected the registered manager to make the clinical decisions around whether people were admitted and to determine if they required residential or nursing care. The registered manager was not a nurse and did not have the appropriate clinical skills to make decisions about whether people needed nursing care for their needs or not.

The physical disability unit was designed for assisting people to live more independently and to become able to live on their own. In April 2014 the registered manager had identified that adapted cutlery, cooking equipment, dining furniture and chairs were needed but these had not been obtained. We had found that the care records for people using this unit only addressed their personal care needs and gave no detail about the goals they were working towards.

Families we spoke with told us that, although their relative wanted them to be fully involved in their treatment and act as their representative, they had not been routinely involved in reviews and one relative told us they had only recently been asked to a review because they complained. We saw that this concern had not been recognised as a formal complaint and therefore no action had been taken to investigate the failing in the system.

Staff had some understanding of the requirements of the Mental Capacity Act 2005 but had not fully introduced either the principles or the appropriate documentation into the home. They had requested Deprivation of Liberty Safeguard (DoLS) authorisations for three people. Staff had not considered preventing other people from leaving units was a deprivation of liberty. One person who was subject to a DoLS wanted to leave a unit, which staff prevented. The staff had not considered how these

Summary of findings

environmental restrictions of the unit could exacerbate their level of agitation and had not considered whether the person could safely access other areas in the home or the garden.

We found that the provider ensured people were recruited safely. Medication was being handled; administered and stored appropriately.

The cook was very knowledgeable about how to ensure people received nutritious, well balanced diets and adept at providing plenty of food. Staff monitored people's physical health and took action if deteriorations were seen.

You can see at the back of the full version of this report along with the enforcement action we took.

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?
The service was not safe

We found that people who used the service and others had not been safe.

Staff had not met people's needs in the Regent House unit or ensured risks to people from the environment were reduced or minimised.

There were insufficient suitably qualified staff employed on the Regent House unit to meet people's needs. Recruitment procedures were in place and appropriate checks were undertaken before staff started work.

Medication was handled, stored and administered appropriately.

Inadequate

Is the service effective?
We found that service was ineffective.

Staff had not received support from the provider to ensure they had the skills, knowledge and experience to provide care to the various groups of people living at the home, particularly individuals in Regent House unit.

The requirements of the Mental Capacity Act 2005 and the Mental Health Act 1983 (amended 2007) were not met. Some people's lifestyles were restricted unacceptably and without due regard to their rights.

The catering staff did ensure people received a healthy balanced diet.

Inadequate

Is the service caring?
We found that the service was caring but improvements were needed.

Staff were very caring but lacked the skills and knowledge needed to ensure they developed therapeutic relationships.

The service was not designed in a way that would promote people's independence and autonomy.

Requires Improvement

Is the service responsive?
The service was not responsive.

People did not receive personalised care that was responsive to their needs.

People were engaged in activities throughout the home and people in Regent House and the physical disability unit went out independently.

When people raised concerns, staff did not recognise them as complaints or allegations of abuse and did not pass to the registered manager to investigate.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The provider did not monitor or assess the service and had not ensured that people who used the service were safe, received effective, caring and responsive services which met their needs.

Staff had not been supported to ensure the way they worked empowered people to live as independent life as possible.

People who used the service and visitors had previously views had been sought about the home but this had not occurred regularly for over six months.

Victoria House

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 27 November and was unannounced.

On the first day the inspection team consisted of an inspector, specialist advisor who was an occupational therapist and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who formed a part of the team specialised in the care of older people.

Before our inspection, we reviewed the information we held about the home and contacted the Clinical Commission Group (CCG) to obtain their views after their recent audit.

During the visit we spoke with 13 people who used the service, seven relatives, the registered manager, the deputy registered manager, one nurse, seven care workers, the cook and two domestic staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not verbally communicate with us. We also undertook general observations of practices within the home and we also reviewed relevant records. These included 11 people's care records, staff files, audits and other relevant information such as policies and procedures. We looked round the home and saw some people's bedrooms, bathrooms, the kitchen, the laundry and communal areas.

Inadequate

Is the service safe?

Our findings

During the inspection of Victoria House we identified significant concerns with a service the provider commenced operating in one of the home's units, namely Regent House. In September 2014 they had begun to operate a dedicated service for younger people with mental health needs.

The provider's statement of purpose and service user guide stated that registered mental health nurses (RMN) worked in the unit from 8am to 8pm seven days a week. At the time of the inspection two care staff worked on the unit. From a review of the rotas we found that no nurses or RMNs were working in the unit. Seven people were residing on the unit and the placing authority's assessments for five people highlighted that six people required nursing care.

We noted that people's files showed they were displaying a range of current and significant risks such as violence, self-harm, suicide, criminality and substance misuse. Staff who were working on the unit had limited understanding of what these risks meant for their practice or how to use the information in assessments. We found that the care staff had not been provided with any support to develop the skills needed to complete appropriate risk assessments around these types of behaviour.

This was a breach of Regulations 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In the Regent House unit we found that the people's care records contained no information to show that the staff at the home had completed any pre or post admission. For five of the seven people using this unit staff had not produced any care plans or risk assessments.

This was a breach of Regulation 9 (Care and welfare); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In the Regent House unit documents from the placing authority showed that some of these people's mental health had recently been unstable and one person had displayed marked symptoms of relapse. Their information highlighted when paranoid and feeling under threat they had previously threatened to harm people. Staff we spoke with and the registered manager were unaware of this information and could not explain what impact this could have for people using the unit and others. Although we raised the matter on the first day on our second visit we found that risk assessments still had not been completed for four people. Staff had completed this for one person but it did not address the risk of harm to others they could present.

We saw that the office space on Regent House was compromising staff and people who used the service safety. The room was so small that if people became aggressive staff had no way to get out of the room, safely manage any physical attack or even move from behind the desk to a safer place. On the first day of the inspection we asked for a risk assessment to be completed which outlined remedial action. When we visited on 27 November 2014 this had not been developed.

During our visits on 18 November 2014 we found that whilst the registered manager did notify the safeguarding team and us of some incidents. There had been occasions when the police had been called either because illegal substances had been brought into the home or people had displayed challenging behaviour. These had not been reported to the LA safeguarding team or us.

People on the physical disabilities unit told us they felt intimidated and frightened by another person who used the service on this unit. Staff confirmed that they had also been told this as did the registered manager but they had not recognised as a safeguarding concern. Therefore no action had been taken to report the matter; investigate the concerns; or mitigate the risk.

This was a breach of Regulation 11 (Safeguarding service users from abuse); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The level of risk associated with the operation of the Regent House unit was significant and we took enforcement action to reduce them. When we visited on 22 December 2014 all of the people at the Regent House unit had moved as had the person in the physical disabilities unit.

The high temperatures on the top floor were raised as concerns last year by us and air conditioners were installed. During the visit this time the temperatures remained excessive and at least 25°c throughout the two days. No action had been taken to routinely monitor the

Is the service safe?

temperature on the top floor or to ensure action was taken when they became excessive. Although air con was provided these were portable units and during our visit staff never turned them on.

On the residential unit the dining room door was locked during the early hours and no jugs of water etc were available so no-one had access to drinks unless staff provided it. Throughout the visit the only drinks made available were at the discretion of the staff. Staff were not monitoring temperatures to make sure people were not at risk of dehydrating nor were they taking action to make sure people did not overheat or dehydrate.

Plaster had fallen off the ceiling in one communal area, which had not been repaired. A significant section of the ceiling above the false ceiling in coffee room had fallen down the week before our first visit. We found that no action had been taken to check that this had not compromised the integrity of the floor above or would lead to more of the ceiling falling down.

A designated smoking area was located in the yard, which people from the physical disability unit used frequently but no action had been taken to ensure the route to it was free from hazards and accessible. There was no lighting and to get there safely people have to be reliant on other people who used the service to give them a hand.

The residential unit for people living with a dementia was restricted to one small part of the top floor. People on this unit only had access to one lounge and a windowless area designated as the dining room. We saw and heard how the limited space exacerbated people's level of agitation and distress. This we found had led to them displaying aggression towards other people on the unit.

A risk assessment of the building in terms of ensuring the safety of the staff and others had not been developed. We saw that documentation and certificates showed that relevant checks had been carried out on the gas boiler, fire extinguishers and emergency lighting.

Other than the downstairs of the Regent House unit being painted the home had not been fully refurbished for a number of years. Paint was chipped, embossed wallpaper had clearly been repeatedly touched up and painted over for some considerable time and the carpets were shabby.

This was a breach of Regulation 15 (1) (Safety and suitability of the premises), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the records of nine staff to check that the home's recruitment procedure was effective and safe. Evidence was available to confirm that appropriate Disclosure and Barring Service checks (DBS) had been carried out before staff started work at the home. DBS checks show whether people have been convicted of an offence or barred from working with vulnerable adults. References had been obtained and, where possible, one of which was from the last employer. The registered manager outlined the processes they followed when recruiting staff, which we found were in line with expectations and effective. Staff we spoke with during the inspection confirmed this to be the case and outlined the induction process, which we found gave them opportunity to become familiar with people who used the service and the expectations of the provider.

There were appropriate arrangements in place for obtaining medicines and checking these on receipt into the home. Adequate stocks of medicines were securely maintained to allow continuity of treatment. We checked the medicine administration records (MAR) together with receipt records and these showed us that people received their medicines correctly. Arrangements were in place for the safe and secure storage of people's medicines.

Senior staff were responsible for the administration of medicines to people who used the service and had been trained to safely undertake this task. We spoke with people who told us that they got their medicines when they needed them.

We found that information was available in both the medicine folder and people's care records, which informed staff about each person's protocols for their 'as required' medicine. We saw that this written guidance assisted staff to make sure the medicines were given appropriately and in a consistent way.

We found that the home was clean and processes were in place to ensure infection control measures were taken. The independent infection control audit completed in October 2014 rated the home at 98% compliant with expectations.

People and relatives we spoke with in the physical disability unit and dementia care services felt the service supported them and was meeting their needs.

Inadequate

Is the service safe?

Relatives said “I feel my relative is quite safe in here, she would not be in here if I felt otherwise, I trust the staff.” “I don’t have any feelings of concern. I think the staff know what they are doing, dad always seems happy enough.” And “My relative needed help I could not give her. I think she is safe and well looked after and that is all I want.”

People said “I like the atmosphere here.” “The staff are good and know how to make sure I’m alright.” And “I’ve never seen anything to give me cause for concern.’

Inadequate

Is the service effective?

Our findings

In the Regent House unit we found that the service user guide and publicity material stated that an RMN who specialised in enduring mental health worked on this unit seven days a week 8am to 8pm. We found that no RMN who specialised in enduring mental health was in post and there was no nursing cover provided on this unit. We spoke with the registered general nurse who covered the night shift. They told us and the registered manager confirmed that they were instructed to provide no support to the Regent House unit. This meant that no nursing cover was provided to the unit at all.

The registered manager informed us that the RMN from the dementia care unit was going to undertake that role once the vacancies on the dementia care unit were covered. The nurse had only recently qualified and had limited experience of working with people who had a forensic history or addictions. The nurse had not yet completed her preceptorship (additional mentoring nurse require after first qualifying) and their supervisor had recently left. From our discussions we found that the registered manager did not understand the importance of preceptorship requirements.

This was a breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person with an Autism Spectrum disorder had been admitted to Regent House although the service guide did not indicate staff could assist people with this need. Staff had not received any training around meeting this need and the person's tribunal papers stated they needed a very structured and secure environment to assist them reduce the risk of self-harm.

On 18 November 2014 we found that staff had not received any training around the Mental Health Act and their role in overseeing requirements of Community Treatment Orders (CTOs), section 17 leave and guardianship orders that people who used the service were detained on. They had received a session in between our visits but on 27 November 2014 staff remained unclear about what actions they needed to take in respect of monitoring conditions of CTOs were not breached. None of the staff working on the Regent House unit had received any other form of training in supporting people with mental health needs. This meant staff lacked the skills needed to look after people with mental health needs.

This was a breach of Regulation 23 (Supporting workers), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that although there was a high dependency nursing unit for people living with a dementia and a nursing unit for people with dementia, there was no information to outline the difference. There was no information to highlight the aims and the goals of the physical disability unit or clearly outline the criteria for admission to both this unit and Regent House unit. Therefore staff had no guidance to assist them determine if placements at the home would meet the person's needs or if the person could be cared for by staff at the home.

This was a breach of Regulation 9 (Care and welfare); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the registered manager was unclear how they should be using the tool used to work out the staffing levels needed at the home. They could not explain if the figures that the tool generated include night time hours and the nursing component. They struggled to outline to us exactly how many staff should be in each unit. We found that some of the guidance the registered manager provided us showed that two nurses were required during the waking hours on the dementia care nursing unit. We found this was not followed and only one nurse was on ever on duty during the waking hours.

This was a breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had some understanding of the requirements of the Mental Capacity Act 2005 but had not fully introduced either the principles or the appropriate documentation into the home. They had requested Deprivation of Liberty Safeguard (DoLS) authorisations for three people but not considered what restrictions the other people who staff prevented from leaving units were experiencing. Neither had they considered how they could apply least restrictive options. This meant the people subject to DoLS were confined to their particular unit.

Inadequate

Is the service effective?

This was a breach of Regulation 18 (consent), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The physical disability unit was designed for assisting people to live more independently and become able to live on their own. The provider had stated that the home could cater for people with physical disabilities but no assessment by qualified people such as OTs had been completed.

Albeit tracking hoists and assisted baths were available the registered manager had identified that adapted cutlery, cooking equipment, dining furniture and chairs were needed but the provider had not supplied them. Therefore people were not assisted to use the kitchen independently and to eat their meals.

This was a breach of Regulation 16 (2) (Safety, availability and suitability of equipment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that many areas of the home were not Disability Discrimination Act compliant both in terms of meeting the needs of people with a physical disability and the needs of people living with a dementia. The dementia care units had not been developed to make the units dementia friendly so were not decorated in ways that enhanced people's level of independence and supported them to find their way around and to their own room.

People on the top floor units were segregated by a keypad door. This reduced the overall available space for people to use and made the residential unit very small. No explanation could be provided for this practice but it meant that on the residential unit the dining area was an enclosed box with no windows and only one lounge was available.

This was a breach of Regulation 17 (2) (g) (Respecting and involving service users), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The dementia care nursing unit was not decorated in ways that enhanced people's level of independence and supported them to find their way around and to their own room. Recognised guidance had not been followed in respect of creating a dementia friendly environment such as how to use colour and material to make it easier for people to make their own way around a unit, find toilets and find meaningful occupation. The operational registered manager had started to review this and take action to ensure improvements were made to this unit.

This was a breach of Regulation 17 (2) (h) (Respecting and involving service users), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A range of adapted kitchen equipment had been purchased and installed in the physical disability unit. Also the services in this provision had been reviewed by a physical disabilities specialist and action had been taken to meet the recommendations. We saw that a wide range of adapted equipment was available throughout the three remaining units.

We spoke with the cook and looked at the home's menu plan. The menus provided a varied selection of meals. We saw that other alternatives were available at each meal time such as a jacket potatoes, soup or salad. The registered manager and cook were able to tell us about particular individuals, how they catered for them, and how they fortified food for people who needed extra nourishment. Fortified food is when meals and snacks are made more nourishing and have more calories by adding ingredients such as butter, double cream, cheese and sugar. This meant that people were supported to maintain their nutrition.

The cook told us that they had a nutrition champion. They told us they regularly met with representatives of other care homes, the local authority and other professionals to discuss nutrition, how illness affects nutrition, special diets and numerous other topics relating to this.

We observed the lunch time of people who used the service. Lunch time was relaxed and people told us they enjoyed the food that was provided. Those people who needed help were provided with assistance. One person said, "The meals are excellent and we are all well fed." Another person said, "The cook does a superb job and the food is always beautifully cooked."

Relatives told us that they felt people had plenty to eat and drink. One relative said "I come here almost every day. I am made very welcome, always a cup of tea and biscuits offered."

The registered manager informed us that all people who used the service had undergone nutritional screening to

Inadequate

Is the service effective?

identify if they were malnourished, at risk of malnutrition or obesity. We saw records to confirm that this was the case. Staff confirmed this was the case and one staff member told us "Our residents get weighed every week, if there is a discrepancy between one week and another, then we weigh them again. If there is a concern then it is brought to the attention of the nurse on duty, who deals with it."

Requires Improvement

Is the service caring?

Our findings

We reviewed 11 people's care records found that the contents were variable. The care records on Regent House unit did not detail people's needs, whether people were subject to any legal constraints such as sections of the Mental Health Act or how they were supported.

This was a breach of Regulations 9 (Care and welfare) and 20 (Records), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

It was also unclear why some people resided on the unit for people with a physical disability, as this was not their need. For instance a person with no physical disabilities had been admitted to the unit because their relative preferred this environment. The people who used the service on this unit did not know what the aim of the service was or how they were to be supported. They were unclear whether they were being assisted to develop skills or just housed there.

This was a breach of Regulations 17 (1) (b) and 2 (g) (Respecting and involving service users), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We made the provider aware of these issues following our visit on the 27 November and on 8 December 2014 we received an action plan identifying how these matters were to be addressed.

When we visited on 22 December 2014 we found that the statement of purpose and service user guide had been updated. Also clear admission criteria had been formulated and implemented.

During the inspection we spent time with people in the communal lounge areas and dining rooms on the three units in the main building. We saw that staff treated people with dignity and respect. Staff were attentive, showed compassion, were patient and interacted well with people. We saw that when people became anxious staff intervened in very supportive ways and used techniques such as distraction and going to quieter areas of the home. The techniques the staff used effectively reassured people. We found staff sensitively and discreetly supported people to deal with their personal care.

The registered manager and staff that we spoke with were showing genuine concern for people's wellbeing. It was evident from discussion that staff working on the units for people with physical disabilities and people living with a dementia knew people very well. They could outline individual's personal history, preferences, likes and dislikes and had used this knowledge to form therapeutic relationships.

Throughout our visit we observed staff and people who used the service were engaged in general conversation and friendly banter. From our discussions with people and observations we found that there was a very relaxed atmosphere and staff were caring. We saw that staff were giving explanations in a way that people easily understood. This demonstrated that people were treated with dignity and respect.

Relatives and people who used the service were very complimentary about the staff working on the three units. People said, "I have never had any concerns about the care my relative gets as the staff have hearts of gold." And, "The staff really want to provide good care."

Inadequate

Is the service responsive?

Our findings

Only one of the five care sets of records reviewed in this unit contained any information written by staff at the home. Neither staff nor the registered manager could outline people's needs on this unit or what actions needed to be taken to support individuals or reduce any potential risks. For example, one person's placing authority's assessment stated they needed a very structured and secure environment to assist them reduce the risk of self-harm. Staff were unable to explain or demonstrate how they were able to provide this type of support.

We found that the assessment documents and care records for people using the physical disability unit only addressed their personal care needs and gave no detail about the goals they were working towards.

This was a breach of Regulations 9 (Care and welfare) and 20 (Records), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider expected the registered manager to make the clinical decisions around whether people were admitted and to determine if they required residential or nursing care. The registered manager was not a nurse and did not have the appropriate clinical skills to make these decisions. The registered manager had made the provider aware of this discussion but there were no plans in place to ensure she was supported to develop these skills.

This was a breach of Regulation 23 (Supporting workers), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person on the Regent House unit with physical disabilities highlighted that the only toilet and shower did not have the adapted equipment they required. We found that no action had been taken to obtain an assessment of their needs then adapt the service accordingly.

This was a breach of Regulation 24 (2) (Cooperating with other providers), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Families we spoke with told us that, although their relative wanted them to be fully involved in their treatment and act as their representative, they had not been routinely involved in reviews. One relative told us they had only recently been asked to a review because they complained. We saw that this concern had not been recognised as a formal complaint and therefore no action had been taken to investigate the failing in the system.

The complaints procedure outline in the statement of purpose and service user guide was inaccurate and gave little detail. The information in this guide was inaccurate as it told people to make complaints to us if they were not happy with the complaint investigation completed by the provider. We heard from relatives and people who used the service that they had made formal complaints. One of the relatives told us that they had complained that they were not involved in reviews. These were not recorded in the home's complaint file so it was unclear what actions had been taken. The registered manager told us she was unaware of these complaints.

We witnessed people raising concerns about the provision in the Regent House unit and physical disability unit but saw that staff did not treat these as complaints; support people to raise them formally; or discuss them with the registered manager.

This was a breach of Regulation 19 (2) (Complaints), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw records to confirm that people had visited or had received visits from the dentist, optician, chiropodist, dietician and their doctor. One person said, "The staff make sure my relative is seen by a GP and will call them even if we are just worried." Another person said, "The G.P. visited straightaway when it looked like I had a chest infection." People were supported and encouraged to have regular health checks and were accompanied by staff or relatives to hospital appointments. We saw people had been supported to make decisions about the health checks and treatment options.

We looked at the care records for six people using the physical disabilities unit and dementia care units and could see that detailed records were maintained of consultations with healthcare professionals, such as the GP, district nurse, consultants and dietician.

Is the service well-led?

Our findings

The provider had commenced operating Regent House unit without ensuring staff were equipped to meet the needs of the individuals admitted. Neither had they ensured the registered manager had the skills necessary to ensure only people the unit could support were admitted.

This was a breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that they were unaware of the systems the provider had previously operated for overseeing the home. So they had developed some systems for monitoring and assessing the effectiveness of the home. But they were in the early days of creating these and many were not in place. They did produce a training matrix that highlighted many gaps but told us they had yet to develop action plans to detail how to address the issues. We found that the system for monitoring the performance of the home could not be confirmed as effective.

Employees of the provider's bank completed the required provider review called a regulation 10 visit and report. No evidence was available to show that the provider used this report or the home's information to ensure the service operated effectively and risks were managed.

As shown throughout this report we identified that there were significant deficits in the performance of the home and skills of the staff. The provider did not have systems in place to ensure these were identified by their staff.

The home has a physical intervention policy but this stated that staff were not to use physical interventions. We found that across the home staff needed to either physically intervene, use sedative medication or mechanical restraints in the form of locking doors. Staff did not understand that their actions would be considered as physical interventions. Due to this policy no physical intervention training was provided and staff did not have access to appropriate recording templates so none of the care records were appropriately completed. No information was provided to show if staff needed to lay on hands how this was to be done.

This was a breach of Regulations 10 (Assessing and monitoring the quality of the service provision) and 20 (1) (Records), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that the registered manager was approachable and supportive. We heard from staff that the registered manager had discussed improvements they intended to make to the home. Staff said, "The registered manager is easy to get on with and I feel comfortable raising concerns with them." And, "They are fair but we have to go to them as they rarely come up here."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **People who use services and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The nursing unit for people living with a dementia has not been designed to ensure people were supported to remain independent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The provider failed to ensure accurate records were maintained in respect of each person using the service and the management of the home.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider had not taken steps to ensure people with functional mental health needs were assessed prior to or following assessment; and therefore, whether they were appropriately placed at the home or if in fact, staff were able to meet their complex needs; or that on accepting them as service users, any risks of serious harm were minimized in terms of your care planning and delivery of care to them, on the basis of creating assessed needs and a recorded care plan, for staff to follow.**

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People were not protected from the risk associated with excessive heat or those related to the use of physical intervention.**

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.**

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **People who use services were not provided with suitable equipment and sufficient quantities of equipment to meet their needs.**

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The provider failed to ensure people were supported to raise complaints or that when they did these were thoroughly investigated.**

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Insufficient numbers of suitability qualified and experienced staff were deployed at the home.**

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Enforcement actions

The provider failed to ensure staff were equipped with the skills needed to meet the needs of people who used the service.

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers **The provider failed to ensure staff worked with other healthcare professionals to develop appropriate care plans for people who used the service.**

The enforcement action we took:
We issued a section 31 Notice of Decision on 12 December 2014 to impose a restrictive condition to prevent the home admitting certain client groups.