Community Health Services Limited

Station House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an urgent inspection on 30 June 2017 following receipt of serious concerns which were sent to the Commission earlier that month. This unannounced inspection was undertaken to check on people's safety, welfare and the general management of the home. On 7 July and 10 July we broadened this inspection into a comprehensive inspection to look at all aspects of service delivery.

Station House is registered to provide nursing care for up to 71 older people. There are two separate units, one for people living with dementia, the other for people who need general nursing or residential care. The service provides long term care for people with nursing and / or dementia care needs. It also provides Intermediate Managed Care and Transitional Care. The aim of Intermediate Managed Care is to promote recovery and independence following an illness or accident. The aim of Transitional Care is to offer care and support for a short period of time, usually when there has been a health and /or social crisis. At the time of the inspection 62 people lived at or were placed at the home.

At the last inspection in August 2016 the service was meeting the requirements of the regulations that were inspected at that time. However, we had found that the service was not always safe because medicines were not always administered safely and securely and made a recommendation about the safe administration and security of medicines.

This location requires a registered manager to be in post. A registered manager was in post at the time of our inspection. 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.

At this inspection, we found that the provider was in breach of regulations 6, 9, 11, 12, 13, 16, 17 and 20 of the Health and Social Care Act Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found that the service was not safe, responsive or well led and not always effective and caring. During the course of the inspection, the response and actions of the registered manager, did not demonstrate that that they had the necessary competencies to manage the home safely and effectively. Quality assurance systems were in place but these had failed to identify uncontrolled risks presented to the people who lived at the home. There was evidence of a failure to analyse incidents and learn from experience when things had gone wrong.

Most of the people spoken with told us that they were safe and received safe and effective care but others expressed concern and one person did not want us to raise their concerns with the staff for fear of repercussions. We found that the management team were not taking effective action to safeguard vulnerable people when they were made aware of allegations of abuse and instances of actual abuse which

had resulted in physical and or emotional harm. The registered manager was defensive and had failed to share evidence of actual abuse and allegations of abuse with the Commission and the local safeguarding authority. This had left vulnerable people without adequate protection. The Commission are looking into specific incidents prior to making regulatory decisions about the incidents known to us.

Investigation into evidence and allegations of abuse were not always carried out thoroughly or effectively so vulnerable people remained at risk. Complaints made by people who used the service and their representatives were not always recorded in the complaints system and a vulnerable person was served notice within 24 hours of their admission to the home because they had contacted an outside agency to raise concerns about the care they had received.

Care and nursing staff were found to be practicing restraint of a service user, in the interest of ensuring that they received effective personal care, but without required training in the use of safe restraint, effective risk assessment or lawful authority. This meant that staff and the service users' health and well-being was put at uncontrolled and unmanaged risk.

Staff understood the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments were in place to assist people with their decision making but the management team had not always acted in accordance with the mental capacity act code of practice.

On the first day of the inspection the home was short staffed because one member of staff had taken sick leave with short notice. We saw that the staff team pulled together, working as an effective team by ensuring that the priority needs of the people resident at the home were met in a safe and effective manner. We saw that there was enough staff to provide safe care. Most of the people we spoke with were satisfied with staffing levels.

During the inspection medicines were administered safely and effectively ensuring the health and well-being of the people resident at the home. Nurses were seen to work hands on alongside care staff providing effective care and sensitive support. This provided for a positive atmosphere in the home with the majority of people glad to inform us that they received safe and effective care and support.

Recruitment and selection of staff was carried out safely with appropriate checks made before new staff started working in the home. This reduced the risk of employing unsuitable people.
People told us they were offered a choice of healthy and nutritious meals. Drinks were available throughout the day and people's dietary and fluid intake was monitored to ensure it was sufficient for good hydration and nutrition. People were complimentary about the meals with several people reporting that the food was excellent.

People in receipt of intermediate care expressed a high degree of satisfaction with the services they had received and one person who spoke with great insight described their experience as nothing short of excellent. Visiting Doctors and other health and social care professionals expressed the same sentiments.

You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

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, 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.

Following our inspection we s we sent the provider a letter of serious concern and that they are working closely with us and updating weekly to improve the service.

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.

Restraint was being practiced in the home without lawful authority, hazards of using restraint had not been identified and risks to the person and staff had not been minimised. This had resulted in the injury of at least one staff member.

The registered manager had failed to notify the Commission of evidence of abuse and allegations of abuse and failed to investigate abuse effectively leaving vulnerable people at risk.

Is the service effective?

Requires Improvement

The service was not effective.

The management team were not always following the principles of the Mental Capacity Act 2005 legislation resulting in the inappropriate use of a mental capacity assessment and the deprivation of a person's liberty of freedom of movement without lawful authority.

Nursing and care staff worked closely with healthcare professionals in the provision of intermediate care and rehabilitation which a number of people described as good or excellent.

People were offered a choice of healthy and nutritious meals. Staff were familiar with each person's dietary needs and knew their likes and dislikes. Several people described the food as excellent.

Is the service caring?

Requires Improvement

The service was not always caring.

A person's human rights to privacy and respect were breached when a member of staff read an email on their smart phone, without consent and reported to management who the person was corresponding with. The person's rights to privacy were breached again when the manager instructed staff to record

their observations in the person's daily records, for all other staff to see.

Care was not always provided in accordance with the person's assessed needs and care plans did not always contain sufficient detail to enable staff to provide safe and effective care.

Throughout the inspection the care and nursing staff were observed to provide sensitive and compassionate care. They took measures to ensure the privacy and dignity of the person and were seen to offer them choice and involve them in decision making.

Advocacy services were available if people needed them.

Is the service responsive?

Inadequate

The service was not responsive.

The management team did not respond appropriately when people made complaints. In one instance a vulnerable person was given notice to leave because they had contacted an outside agency to raise concerns about their care and welfare.

Some people had received care that was tailored to their individual needs and personal preferences and were able to report excellent standards of care and rehabilitation.

Is the service well-led?

Inadequate

The service was not well led.

People who used the service were placed at risk of harm because the registered manager failed to notify the Commission and the local safeguarding authority of serious incidences including allegations and evidence of abuse and neglect and failed to respond in a way that would ensure risks were mitigated.

The registered manager lacked knowledge of their requirements and responsibilities under the regulations and was failing to demonstrate the necessary skills and competencies to manager the home.

Audits of the care home had not identified the concerns found on this inspection because there was a lack of effective governance and quality assurance and oversight.

Station 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.

The inspection took place on 30 June, and was unannounced. Two additional announced inspection visits were undertaken on the 7 and 10 July 2017.

The inspection team consisted of one inspector. Before our inspection we reviewed the information we held on the service. This included notifications we had received from the registered provider, about incidents that affected the health, safety and welfare of people who lived at the home and previous inspection reports. We also checked to see if any information concerning the care and welfare of people living at the home had been received.

We reviewed the Provider Information Record (PIR) we received prior to our inspection. 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. This provided us with information and numerical data about the operation of the service. We used this information as part of the evidence for the inspection. This guided us to what areas we would focus on as part of our inspection.

The methods used during this inspection included talking to people using the service, their relatives and friends or other visitors including visiting health and social care professionals. We interviewed staff, undertook pathway tracking, observed care practice, read records including personal care records for five people who used the service, staff recruitment records, staff training records, deprivation of liberty safeguards and mental capacity assessments, and quality assurance records. We also looked at a range of other records associated with the management of the home.

People spoken with included the registered manager, deputy manager, two unit managers, ten members of staff on duty, twelve people who lived at the home and eight visiting relatives and friends. We also spoke with six health care professionals, including three visiting doctors an occupational therapist and a

representative of the local NHS clinical commissioning group (CCG).

Prior to and after the inspection we spoke with representatives of the local social services department and gained their views on the quality of care provided at the home. This helped us to gain a balanced overview of what people experienced whilst living at the home.

Inadequate

Is the service safe?

Our findings

Most of the people spoken with told us that they were safe and received safe and effective care but others expressed concern and one person asked us not to mention their concerns to staff for fear of repercussions. They said, "Please don't say anything. I'm already in their bad books".

We found that the management team were not taking effective action to safeguard vulnerable people when they were made aware of allegations of abuse and instances of actual abuse which had resulted in physical and or emotional harm. The registered manager had failed to share evidence of actual abuse and allegations of abuse with the Commission and the local safeguarding authority. This had left vulnerable people without adequate protection. The Commission are looking into specific incidents prior to making regulatory decisions about the incidents known to us.

In May 2017 the local social services team conducted an investigation into an allegation of neglect at Station House and found that neglect leading to physical harm was substantiated. The registered person's did not notify the Commission of this abuse.

On 19 June 2017 we received allegations of neglect at the hands of night staff at the home and liaised with social services. Social services confirmed that they had also received allegations of abuse and were investigating them under agreed adult safeguarding procedures. The social worker had visited the home and spoken with the registered manager and unit manager and had asked the home to investigate. The registered persons did not notify the Commission of these allegations of abuse and poor attitudes of night staff.

On the 21 July 2017 we received a report from social services that they had asked the home to investigate an allegation of abuse made by a resident to an ambulance staff in May 2017. The person had alleged poor care at the hands of night staff. Social services reported that the registered manager had investigated this case along with complaints received from another service user about the attitude of night staff. As a result abuse was substantiated. Five staff had been given letters of concern which had been put on their files for 12 months and one staff member had received a final written warning. We had not received notification of this abuse from the registered persons. The registered persons did not notify the Commission of these allegations of abuse and poor attitudes of night staff.

The incidents outlined above constitute a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009, statutory notifications in relation to abuse or allegations of abuse should be made to the Commission without undue delay.

The deputy manager told us that they were aware of the investigation report and had discussed it with the investigating social worker. They told us that they had raised the matter at a following clinical staff meeting. We looked at the relevant records of a clinical staff meeting dated May 2017 and found that the only mention of this incident was to remind staff to order the correct medication.

Whilst social services had substantiated abuse they had not determined why the person had not received appropriate levels of care or why staff had failed to acquire prescribed medication. It fell to the registered persons to identify through investigation what had gone wrong, and what needed to be done to put things right. This important aspect of the registered person's duties and responsibilities had not been carried out. The deputy manager, nor the Regional Director for the registered provider were able to explain why they had not investigated this abuse to ascertain why nursing staff had not monitored the person's condition or acquired the appropriate medication as prescribed by their doctor. The registered manager denied any knowledge of the investigation or its outcome.

We contacted the home and asked the deputy manager to make retrospective notifications and provide copy of the investigation report. The retrospective notifications were made in late July 2017 along with a part completed investigation report. This revealed that allegations of abuse had been raised in respect of a third person at the hands of night staff. Again the registered persons had failed to notify the Commission about an abuse and had not reported the allegation of abuse to the local safeguarding authority.

When we carried our inspection on the 30 June 2017 we asked the registered manager why we had not received notification of these allegations of neglect. The registered manager explained that she did not understand her responsibilities as a registered person under the regulations. We asked to see the investigation report which covered allegations of neglect on the 14 June 2017, the 17 June 2017 and allegations of rough handling at the hands of a care worker. We could see that the investigation was not sufficiently thorough and important evidence had been omitted. The investigating social worker for the local authority and the link social worker for the home had not been made aware of the disciplinary action taken against night staff at the beginning of June, demonstrating a lack of required openness and candidness with the safeguarding authority. This meant that vulnerable people were not safeguarded from abuse and remained at risk of abuse.

This is a breach of Regulation 13 of The Health and Social care Act 2008 (regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

On the second day of our inspection we found that care and nursing staff were practicing restraint of a person using the service, in the interest of ensuring that they received effective personal care, but without required training in the use of safe restraint, effective risk assessment or lawful authority. This meant that staff and the person who used the service's health and well-being was put at uncontrolled and unmanaged risk.

Data provided by the registered provided highlighted a significant risk at Station House in relation to prevalence of decubitus ulcers, commonly known as pressure ulcers.. These are areas of skin that have been damaged by irritation and/or continuous pressure on them. They should in most cases be preventable if properly managed. Because of this we looked at the care records of the person who had been found to have undocumented pressure damage to their heels on their return home in early July 2017. This person had been nursed in bed because they were assessed as being at high risk of skin integrity concerns including pressure ulcers. The care plan stated regular repositioning was required. This appeared inadequate because it did not state the frequency of repositioning throughout the day and night. Their repositioning charts showed a six hour gap on 22/6/17, 5 hour gap on the 23/06/17 a ten hour gap on the 2/7/17 between 11.00 and 21.10 and a 6 hour 25 minute gap also on the 2/7/17 between 21.10 and 03.35 hours the following day. This apparent lack of repositioning could have been a contributory factor to the damage to their heels on discharge from the home.

We looked at another person's records and could see that they had developed a moisture lesion in early July 2107. This person was also assessed as being at high risk of skin integrity concerns including pressure ulcers. Their care plan also stated 4 and 6 hourly repositioning and repositioning charts showed consistent 4 hourly day and 6 hourly at night from the 30 June to the date of the visit on 7 July. Nursing staff reported that the moisture lesion was healing but the frequency of repositioning was not increased when the moisture lesion close appeared. Another person assessed at high risk of skin integrity concerns including pressure ulcers care plan also stipulated 4 hourly repositioning during the day and six hourly repositioning at night. On the 10 July 2017 we asked to see this person's repositioning charts but most of them were not available. The unit manager told us that they had been misplaced and were not made available to the Commission until 25 July 2017. These showed consistent 4 hourly day and 6 hourly at night. Repositioning of 4 hours during the day and 6 hours at night is inadequate for a person assessed at high risk of pressure area damage.

The issues outlined above constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations Safe Care and Treatment.

The registered manager was asked to investigate how the person described above had developed damage to their heels.under locally agreed safeguarding procedures. In the registered manager's report to social services an explanation was offered which implicated a third party care agency but did not highlight the not insignificant gaps in the person's repositioning charts or failings in their care plan. This showed a marked lack of candidness on the part of the registered manager, a failing to investigate allegations of abuse effectively and a failing to monitor and evaluate care.

This is further breach of Regulation 13 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

On the first day of the inspection the home was short staffed because one member of staff had taken sick leave with short notice. We saw that the staff team pulled together, working as an effective team by ensuring that the priority needs of the people at the home were met in a safe and effective manner. We looked at worked rotas for day and night staff, ancillary staff and cooks and could see that there were enough staff to provide safe and effective care. Most of the people we spoke with were satisfied with staffing levels.

During the inspection medicines were administered safely and effectively ensuring the health and well-being of the people at the home. Nurses were seen to work hands on alongside care staff providing effective care and sensitive support. This provided for a positive atmosphere in the home with the majority of people glad to inform us that they received safe and effective care and support.

Recruitment and selection of staff was carried out safely with appropriate checks made before new staff started working in the home. This reduced the risk of employing unsuitable people.

Requires Improvement

Is the service effective?

Our findings

The atmosphere in the home was relaxed and sociable throughout our inspection. Whilst some people raised specific concerns about the effectiveness of some aspects of care all had something positive to say about the staff, the food, facilities and services and/ or the standard of care provided. For example, one person praised the concerted effort made by the intermediate care team to get them mobile again. They told us that, "The staff and the food were nothing short of excellent". They spoke with insight about the expertise of the staff team that had supported them to regain their independence. They explained their daily routine and how the well trained staff provided precisely the right amount of care and support to ensure they developed their skills at the same time as maintaining dignity and respect. We could see that they were involved in the care planning and delivery of their care. Another person remarked that, "The home was short staffed as can been seen because staff are rushing about, but despite this everything worked well. " They explained that they received safe and effective care, their needs were met, staff were helpful, sensitive and polite. Another person told us how they were looking forward to going home the following week but explained that their experience had been excellent. Another person told us that they had only moved in the day before after a long stay in hospital. They told us that they were, "Settling in, everything was fine, so far, they felt safe". They also said, "The food is good. I had a good breakfast this morning- sausage bacon and egg for the first time in four weeks". Two others sat together told us that they were happy, well looked after and both felt safe. One said, "We have to wait sometimes but no longer than five minutes, everything is good including the food and the staff".

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 for themselves. The Act requires that, as far as possible, people make their own decisions and are supported 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and could see that by and large they were. Nursing and care staff were knowledgeable about the Mental Capacity Act and we observed them actively supporting people to make choices and decisions. They were patient and sensitive to people's needs modulating their voice to help people who may have had difficulty hearing or absorbing information to understand them.

We looked at the DoLS for a person who resided at the home who presented with challenging and aggressive behaviour. The unit manager told us that staff used restraint when providing personal care for this person to prevent them from injuring themselves and staff. The registered manager told us that this use of restraint had been discussed and agreed with the supervisory authority and that the use of restraint featured in the persons DoLS. We checked this person's DoLS and found no mention of the use of restraint. Further discussion with a representative of the supervisory body found that the registered manager had not

formally applied for formal authority regarding the use of restraint as required in accordance with the requirements of the MCA and the regulations. This meant that that this person was being subject to a restriction of their liberty without lawful authority. This is a breach of regulation 11 of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014 as person can only be subject to a deprivation of freedom of movement in accordance with the requirements of the MCA.

In another instance we found that a MCA assessment had been completed for a person who did not have any form of mental impairment. This is inappropriate. This MCA assessment had been completed on the day the person moved in because they had requested bed rails to keep them safe. Their care needs assessment which had been completed before they moved in showed that there were no doubts about this person's mental capacity before they moved in and in fact bedrails were provided at their previous residence as the document showed. The registered manager told us that they did not like bedrails as they believed them to provide hazards in themselves. This is no reason to doubt the mental capacity of the relevant person. We spoke with the relevant person and had no doubt that they had capacity to make such a decision. The first test of a mental capacity assessment is to answer the question whether the person has a mental impairment. If this is not present it is inappropriate to continue.

Throughout this inspection the staff team were seen to work effectively together. When they were short staffed we observed how they worked diligently prioritising people who presented with the highest level of need, communicating with each other and providing safe and sensitive care. The staff told us that they appreciated the support provided by the management team. They said they were well led and benefited from effective training and regular supervision.
We could see that health and social care professionals were routinely involved in the delivery of care. During the course of this inspection we spoke with several health and social care professionals including three visiting doctors an occupational therapist and a representative the local NHS Clinical Commissioning Group (CCG) and a District Nurse Manager based with the intermediate care team. All without exception praised the staff and the management team for their cooperation and the standard of care provided.

We observed mealtimes during the inspection and could see that people enjoyed the overall experience. They told us that their likes and dislikes were catered for, as were specialist diets. Where required adapted tableware was provided which enabled people to remain as independent as possible. This included cups with lids or straws and plate guards. We observed staff supporting people to eat their meals in a sensitive and caring manner, going at their pace and giving them time to enjoy their meal. People had a nutritional risk assessment in their care records which identified those who were at risk of obesity or malnutrition. People`s weights were monitored frequently to help people maintain a healthy weight. Food and fluid charts were maintained, monitored and evaluated to ensure that each person had sufficient fluids and nutrition. We observed staff writing up food and fluid charts together at the end of the shift. The unit manager told us that such records were ordinarily written up contemporaneously as required but in this instance, because they were short staffed staff had left recording until the shift had finished so they could prioritise care first.

We found that the home was clean and odour free throughout our inspection. The kitchen had been rated 5 Star, by the local Environmental Health Officers. This is the highest rating a food provider can be given.

Staff told us they benefitted from regular training and updates. Care staff had completed or were working towards national qualifications in care. Staff had also completed other training including; Dementia, dignity and respect, equality and diversity, diabetes, moving and handling, Mental Capacity Act and Deprivation of Liberty training, first aid, food safety, safeguarding vulnerable adults, infection control and health and safety. Training needs were identified in relation to the management of challenging behaviour including safe

restraint. The registered manager told us that arrangements were being made to ensure this was provided in the near future. They received regular supervision meetings with managers to discuss their performance and development and the support they need in their role. Staff told us they felt well supported and appreciated the direction and leadership provider by the managers.

Requires Improvement

Is the service caring?

Our findings

All the people spoken with during the inspection made positive comments about the way staff provided care and support. One person said, "I'm very happy here, very well looked after, the staff are lovely with me and I feel very safe." Another person said, "The staff are very good, very helpful. They are working very hard because they are short staffed but if you ask for help they come to you within five minutes or so they are caring and treat me with respect. I have no complaints". Others made similar comments and one person who had moved in the previous day told us that they had been made to feel welcome and were settling in nicely. Two people spoken with told us that they were unhappy at the home and had raised concerns about their care. Some of the people spoken with recalled that they had care plans and had been involved with them. They told us that they were happy with them. One person had a detailed knowledge of the arrangements made for their care and was able to discuss how the nursing staff had listened to them and taken their views into consideration. Prior to and during the inspection we spoke with 11 visiting relatives and friends of the people who lived at the home. Their views as to the standard of care varied. Some told us that they were satisfied with the standard of care that had been provided; others told us that there had been times when care provided had not met expectations of what a good home should provide.

We observed people chatting amongst themselves, with their numerous visitors and from time to time with staff. This made for a social and welcoming atmosphere in the home. Throughout the inspection the care and nursing staff were observed to provide sensitive and compassionate care. We observed them taking measures to ensure the privacy and dignity of the person, such as opening and shutting bedroom and bathroom doors discreetly to preserve privacy and dignity. People were addressed in the name of their choosing and were offered choice and involved in decision making wherever possible. We observed the way staff always knocked on bedroom doors and waited a moment before seeking permission to come in.

We could see that staff knew how to provide safe, effective and compassionate care but were concerned to find evidence that a person's rights to privacy had been disrespected and abused. We read the records of a person who staff were aware had raised concerns about the standard of care. We found an entry in their records which recorded an occasion when a member of the staff team had read a message on the person's smart phone and saw that they were corresponding with the Commission. This was a blatant disregard for this person's rights to privacy, which, according to their records, was compounded when a manager instructed the member of staff to record their observations in the person's daily records. This is a breach of their human rights to privacy.

This is a breach of the the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10 Dignity and respect.

Staff spoken with presented with a good knowledge of the needs, likes and dislikes of some of the people who lived at the home but lacked vital knowledge in respect of the care of others. Because of the nature of the home's purpose to provide intermediate and transitional care, there tends to be several people moving in and several others moving out in any given week. Therefore the importance of suitably detailed and person centred care plans is emphasised because staff need to rely on these to gain an sufficient

understandings of each person's needs. Some of the care plans seen contained sufficient detail to enable staff to gain a good working knowledge of the needs and personal preferences of the person but others lacked vital information. For example, some of the care plans seen on pressure area care were inadequate because they did not stipulate the frequency of required repositioning particular to the person's assessed needs. In one instance we found that the person's care plan had been reviewed when their risk of developing pressure sores had increased but not revised so repositioning had carried on at the previous frequency which was inadequate. Another person who had been subject to restraint, did not have a care plan on the safe use of restraint. This meant that staff were unable to gain a consensus of approach which is vital in the delivery of safe restraint. When we spoke with staff they were unable to tell us what holds they would use when using restraint. This meant that the person was placed at risk of receiving unsafe or inappropriate care.

This is a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

We spoke with six visiting care professionals during the course of the inspection including three doctors, an occupational therapist, a District Nurse managers and a representative of the NHS Clinical Commissioning Group. All spoke highly of the standard of care provided often describing the standard of nursing and personal care as excellent. We could see that managers and staff had developed good working relationships with visiting health care professionals who worked together in the best interest of the people who used the service.

There was information on people's personal preferences around the end of life and appropriate documentation regarding resuscitation. We saw people's wishes were clear and staff were aware of these. One of the professionals spoken with spoken with told us that they had been involved in the provision of training to staff on end of life or palliative care and resuscitation. They told us that the staff team had a reputation for the provision of excellent palliative care working effectively and sensitively with the person their family and all involved.

Inadequate

Is the service responsive?

Our findings

We asked people who lived at the home whether care provided was centred on their individual needs. Their experiences varied considerably. Some people were able to recall that they had care plans and told us that they were satisfied with them. One person spoke with great detail as to how staff had involved them in their rehabilitation every step of the way from assessment on admission through care planning and subsequent development. Another person told us how they had benefited from rehabilitation with improved mobility which would enable them to return home and continue living independently with support from a care agency. One the first day of the inspection another person told us that they were in "bad books" and asked us not to say anything. We reassured them that by raising concerns managers would be able to address them. It transpired that this person felt they were in the home's bad books because of a misunderstanding over the use of continence aids. This was raised with staff who took action to reassure the person. One person told us how their admission had involved in the assessment process and whilst they spoke positively about the care provided by day staff their experience at the hands of night staff had on occasion been inadequate. They told us that they had raised complaints but the service they had received deteriorated rather than improved. They told us that they were unhappy and managers had made little or no attempt to talk to them to reassure them or ascertain what was troubling them.

We looked at the home's complaints records and could see that the last recorded complaint was received in 2016. We asked the registered manager about complaints made about the care provided by night staff and they told us that they had not received any such complaints. However, we could see from a person's daily records that the home was aware of a number of complaints which should have been recorded and thoroughly investigated under the home's complaints procedures. We went on to find that the registered manager had received recent complaints from three other people who lived at the home which in one case included an allegation of abuse. Information provided by the deputy manager and regional manager confirmed that six members of the night staff team had been disciplined including one who had been given a final warning.
When a fourth person raised concerns about the standard of care provided by night staff the registered manager failed to address the concerns in accordance with the provider's policies and procedures but responded defensively. The registered manager informed the person's social worker that notice will be served on the person to leave. This action was entirely inappropriate and is abusive in itself. No person making a complaint about the care they receive should suffer any detriment for doing so.

This constitutes a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 16 Receiving and acting on complaints.
Relatives told us that they had seen care plans and were happy with their content. Some of the care plans seen were person centred in that they clearly reflected what the person needed help with and the way they wanted it to be provided. Others needed further development. For example one person who was subject to physical restraint during the provision of personal care. How this was to be provided was not documented in any of their care plans so staff had not been able to develop a consensus of approach. Another person's care plan referred to them requiring regular position changes to protect them from pressure are damaged. This care plan was not person centred because it did not specify what regular meant. Regular for one person

might mean inadequate for another person. Care plans need to be tailored to the person's individual needs and circumstances so they may receive safe and effective care.

There was arrange of activities on offer morning and afternoons seven days of the week. These were facilitated by two staff known as "Lifestyle Co-ordinators" . They provided a four week programme of activities which included the "Daily Sparkle reminiscence session", "Try a smoothie", "Connect four" and "Manicure" . People told us that they were satisfied with the range of activities on offer.

Inadequate

Is the service well-led?

Our findings

Most of the people spoken with during the course of the three day inspection told us that the home was well run. Visiting professionals all praised the home and the standard of care provided. They told us that they were of the view that Station House is a well-run home that benefits from a well-managed and effective team of staff. One of the three doctors spoken with told us that the management team was passionate about the work they do and are committed to the provision of safe and effective care that meets people's needs.

Our initial view of the managers responsible for the day to day running of the home was that they presented as a strong and cohesive team that had the benefit of excellent communication between themselves and effective working relationships with all health and social care professionals involved. However, we found evidence of poor and inadequate communication between managers, ineffective practice, a lack of candour and a lack of knowledge regarding the requirements of the regulations designed to ensure safe and effective care. The registered manager responded defensively and inappropriately when a vulnerable person raised complaints and did not demonstrate that they had the necessary competencies to manage the home safely and effectively.

The regional director was in the home on the third day of our inspection and was auditing various aspects of the service. We could see that the provider had systems in place including monthly audits of differing aspects of the service's performance, unannounced audits carried out by the provider's governance and quality team, regular staff and clinical staff meetings, meetings with the people who used the service and their relatives. However, none of these audits and checks had identified the multiple breaches of the regulations and the risks of poor and ineffective care identified during our inspection.

This constitutes a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

The registered manager had not notified the Commission of recent allegations of neglect made by a vulnerable person as in accordance with the requirements of the regulations. They told us that they were unaware of the requirement to do so. The registered manager told us that they were unaware of a previous report from social services which had substantiated abuse leading to physical harm which the deputy manager had discussed with the investigation social worker and raised at a clinical staff meeting. The registered manager nor the registered provider had reported this previous abuse to the Commission. There had been no written explanation or apology given to the relevant person as in accordance with the requirements of the regulations. This is a failure to notify the Commission of abuse or allegations of abuse as required in accordance with the Care Quality Commission (Registration) Regulations 2009: Regulation 18.

We found that an allegation of abuse had not been reported to the local authority in accordance with locally agreed adult safeguarding procedures or to the Commission in accordance with the requirements of the regulations. Whilst the manager had substantiated that abuse had occurred they did not provide a written explanation or apology to the relevant person as in accordance with the requirements of the regulations or

see fit to share their findings with the Commission or local authority.
When the inspector checked the complaints records and asked the registered manager whether they had received any other complaints this year they responded they had not. This transpired to be in accurate and in fact several complaints had been received against night and disciplinary action had been taken against six of them.

This is a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 20 Duty of candour as the provider had failed to act in a transparent way in relation to the care and treatment provided to service users when things had gone wrong..

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the commission of abuse and allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans lacked the required detail that would ensure care was appropriate and provided in a way that would meet the relevant person's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect An entry in a person's daily records showed a disregard for ther relevant person's rights to privacy, which, was compounded when a manager instructed the member of staff to record their observations in the person's daily records. This is a breach of their human rights to privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent A person was subject to physical restraint without lawful authority.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person were not doing all that is reasonably practicable to mitigate the risks of people at risk of pressure area sores. Restraint was being practiced in the home without lawful authority, hazards of using restraint had not been identified and risks to the person and staff had not been minimised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not effectively or adequately protected from abuse. The registered persons had failed to notify the Commission of evidence of abuse and allegations of abuse and failed to investigate abuse effectively leaving vulnerable people at risk. A service user was being deprived of their liberty, in that they were physically restrained, without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person's did not respond appropriately when people made complaints. A vulnerable person was given notice to leave because they had contacted an outside agency to raise concerns about their care and welfare. Complaints were not always recorded, or investigated and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems established to ensure compliance with the regulations were not operated effectively. Audits of the care home had not identified the concerns found on this inspection because

there was a lack of effective governance and quality assurance and oversight.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered persons did not always act in transparent way when things had gone wrong. Relevant person's were not always provided with a written account, given an apology and an explanation and details of action taken to prevent further occurrence.