Rowans Care Homes Limited

Burton, Bridge and Trent Court Care Centre

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

This inspection was unannounced and took place on 13 and 14 July 2015. At our last inspection in October 2014 compliance actions were issued as we identified that improvements were needed regarding the recruitment practices in place, the management of medicines, consent to care and treatment and meeting people's nutritional needs. The provider sent us a report in April 2015 explaining the actions they would take to improve. At this inspection, we found improvements had been made regarding recruitment to ensure staff's suitability to deliver care before they started work. We found insufficient improvements had been made in other areas where compliance actions were left.

Burton, Bridge and Trent Care centre is registered to provide accommodation for 99 people. They can offer support to people with dementia and mental health related conditions. Bridge Court, Burton Court and Trent Court are three separate buildings but are registered with us as one location. Bridge Court provides nursing and

Summary of findings

residential and dementia care to older people. Burton Court provides nursing care to women with mental health related conditions and Trent Court provides nursing care to men with mental health related conditions. All three units are allocated a unit manager.

At the time of our inspection 54 people used the service. On Bridge Court there were 17 people, on Trent Court there were 23 people and on Burton Court there were 14 people.

There was no registered manager 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.' The provider had applied to register each unit as separate registered services. However, due to the continuous resignation of managers this had not been completed.

We identified areas of unsafe, ineffective and unresponsive care. This was because the service was not well led. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Although people felt safe and relatives did not raise any concerns, some people's safety was compromised. Some staff did not have the skills and competence to support people safely. Some moving and handling practices put people at risk of harm due to the limited knowledge and competence of some staff. Some equipment used was not safe and put people at risk of injury. Some equipment was not maintained to ensure it was suitable for use.

Risk assessments were not always followed or consistent to ensure people received safe care. Some staff had limited knowledge and understanding on how to protect people from abuse. The rights of people who required physical intervention were not protected as no information regarding these interventions was recorded. Improvements were needed in the management of medicines to ensure people's prescribed medicines remained suitable. People were not always offered pain relief when needed.

The Mental Capacity Act 2005 (MCA) was not always followed to ensure that important decisions about people's care were made in their best interests when required. Where people were unable to consent, mental capacity assessments and best interest decision had not always been completed and people's consent was not always gained before care interventions were delivered.

People's nutritional needs were not always met due to staff's lack of understanding regarding people's nutritional requirements. People assessed as high risk of choking and aspiration were put at risk. People were not always supported to eat their meals in a timely way, which meant people did not receive their meals at a suitable temperature to be enjoyed.

People were in general referred to healthcare professionals but poor communication between staff meant that some health care needs were not always referred when needed. Some staff's had limited understanding of English language and were unable to communicate effectively with people to ensure their needs were met.

Most staff interactions with people were kind and patient but some practices observed were not individualised to ensure people's needs and wishes were respected and their dignity maintained.

Staff did not have clear direction on how to support people who demonstrated behaviours that put themselves or others at risk to ensure the support people received met their needs.

People's social and recreational needs were not met consistently, which meant that some people's social well-being was not met.

There was inconsistent leadership and direction for staff to ensure people's needs were met. Some staff did not feel comfortable raising concerns which demonstrated that a transparent and open management approach was not in place. Quality monitoring systems were not up to date to enable managers to make improvements were needed.

Sufficient staff were available to support people and safe recruitment practices were in place to ensure staff's suitability before they started work. People knew how to make a complaint and we saw these were investigated.

Summary of findings

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Since our inspection the provider has gone into administration. The administrators have instructed consultants to oversee the running of the home on their behalf.

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

People were not safe because staff's lack of knowledge put them at risk of harm. Some equipment used was not safe which put people at risk of injury. Improvements were needed to medicines management. Sufficient staff were available and the recruitment practices in place ensured staff's suitability.

Inadequate

Is the service effective?
The service was not effective

Some staff did not have the skills and knowledge to ensure people's needs were met. The Mental Capacity Act 2005 was not consistently used to demonstrate decisions were made in people's best interest. Some people's nutritional needs were not met or monitored. People had access to healthcare services but referrals were not always made in a timely way.

Inadequate

Is the service caring?
The service was not consistently caring

Staff were caring towards people but the support people received was not always individualised. Some staff could not effectively communicate with people and other staff. People were not always supported in a timely way. People were not always supported to maintain their dignity.

Requires improvement

Is the service responsive?
The service was not responsive

Care plans were not always followed by staff to ensure people's needs were met. Communication was poor which contributed to people receiving support that did not meet their needs. Staff did not have clear direction on how to support people. People's social needs were not fully met. Complaints were responded to in a timely way.

Inadequate

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

There was no registered manager in post and the changes in the management structure had led to inconsistencies in the quality of service provided to people. The home was not managed in a transparent way to ensure people were protected from poor practice. The training provided to staff did not ensure their competency was assessed. Quality monitoring systems were not up to date and audits seen showed these had been completed incorrectly.

Inadequate

Burton, Bridge and Trent Court Care Centre

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 13 and 14 July 2015 and was unannounced.

This inspection was carried out by a total of four inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not send the provider a Provider Information Return (PIR) request prior to this 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. However, we asked the provider if there was information they wished to provide to us in relation to this.

As part of our planning we reviewed information that we held. This included notifications from the provider. A notification is information about important events which the service is required to send us by law. We also looked at information from the local authority regarding their ongoing involvement. This was following the large number of safeguarding referrals and investigations made over the last 18 months about the support provided to people who used the service.

We looked at information received from relatives and from the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with ten people who used the service, three people's visitors, one professional visitor, ten care staff and three nurses. We also spoke with the person overseeing the management of the home, the unit manager of Burton Court and the deputy unit manager at Trent Court. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. We used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care plans for ten people. We checked three staff files to see how staff were recruited, we looked at training records to see how staff were supported to deliver care and support appropriate to each person's needs. We reviewed management records of the checks the manager made to assure themselves people received a quality service.

Inadequate

Is the service safe?

Our findings

Equipment used was not safe and put people at risk of injury. For example on Bridge Court we saw one person using a wheelchair with a broken arm rest. This meant the person was at risk of trapping their fingers. Another person was transferred using a wheelchair that was unsuitable for use. This was because unlikely other wheelchairs where the brakes could be locked into position, the mechanism to apply the brakes on this chair were situated on the handle bars. These had to be held in position to keep the brakes on. This was not done during the transfer, resulting in the person's chair tipping back which put them at risk of harm. This demonstrated that equipment was not properly checked or maintained to ensure it was suitable and safe for people to use.

We identified that other equipment was not maintained to ensure it was suitable for use. For example a new bath in Bridge Court did not reach the required temperature for people to bathe in, and the water ran cold. Staff told us that this bath could not be used. The bath hoist had broken off on another bath and could not be used. Some people did not have access to hot water in their bedrooms and one person did not have access to any running water in their bedroom.

We received information from the Clinical Commissioning Group (CCG) that recent weight charts seen for people at Bridge Court showed consistent weigh loss. The CCG is a clinically-led statutory NHS body responsible for the planning and commissioning of health care services for their local area. It was identified that the scales used had not been checked for accuracy. At our inspection the staff said that the scales had not been checked for accuracy. This meant that the equipment used to weigh people had not been maintained to ensure accurate weights were provided.

This is a breach of Regulation 15 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Risk assessments were in place but we observed these were not always followed or consistent to ensure people received safe care. For example one person had fallen five times over a seven day period. Although a risk assessment was in place following the first fall, which stated the person was at high risk, no action had been recorded on how this risk was to be managed. One person had a risk assessment in place regarding cushions that should be in place to protect their arms, when sitting in an arm chair. On both days of our inspection we saw the cushions were not in place.

This is a breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People confirmed that they were comfortable with the staff team and felt safe however staff's understanding of safeguarding people was inconsistent. Staff we spoke with on Trent and Bridge Court knew and understood their responsibilities to keep people safe and protect them from harm. They were aware of the signs to look out for that might mean a person was at risk. On Burton Court the staff we spoke with had limited knowledge regarding signs of abuse and the types of abuse. For example, staff could only give a brief explanation of physical abuse, such as unexplained bruising. Staff told us they had received safeguarding training but could not demonstrate their knowledge and what they had learned. This meant that people were at risk of harm as staff competency in identifying abuse was limited.

This is a breach of Regulation 13 (2) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw where physical intervention was required to support people, no records were held regarding the type of physical intervention used and the duration of this intervention. This meant there was no audit to assess and monitor the amount of physical intervention used at Trent Court. We therefore could not be assured that people were supported in a safe way and in accordance with their care plan.

On Burton Court we observed that a person's movement was restricted by a member of care staff whilst supporting them to eat. The person had no verbal communication and was supported to eat their lunch by the staff member. During the meal this person indicated through body language that they had eaten sufficiently. The person turned their head away and attempted to stop food going into their mouth by using their arms. We saw that the staff

member ignored this communication and continued to put food in this person's mouth against their wishes. This showed us that this person's human rights were not upheld and they were not treated with respect.

This is a breach of Regulation 13 (4) (b) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At the last inspection in October 2014 improvements were needed in the management of medicines to ensure they were managed safely. At this inspection the improvements identified had been met but we found other concerns regarding medicines management. On Trent Court we saw that some medicines prescribed on an as required basis (PRN) were being given on a regular basis. There was no record of why staff were administering this medicine regularly. Staff confirmed they had not contacted people's doctors to review if this medicine should be prescribed on a regular basis. This meant that safe systems were not in place to ensure people's needs regarding certain PRN medicines were being met.

We identified that people may not be receiving pain relief medicine as needed. Protocols were not always in place to guide staff as to when pain relief should be given. A protocol provides staff administering PRN medicine with detailed information to ensure this medicine is administered safely and as required. Where protocols were in place, we observed two people on Burton Court displaying behaviour described in their PRN protocol as meaning they were in pain or discomfort. However no pain relief was offered or provided to them. On asking three members of staff, including an agency nurse how one person demonstrated they were in pain, we were given different responses from each member of staff.

One person living on Burton Court received their medicine covertly. Covert administration is when medicine is hidden in food or drink and the person is unaware that they are taking this medicine. We saw that this medicine had not had a review for 18 months to ensure it remained effective and safe for the person to use.

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw that medicines were kept securely in a locked cupboard to ensure they were not accessible to unauthorised people. We looked at the medicine administration records for people and saw that nurses had signed to demonstrate when medicines were administered. People told us that they received their medicines on time.

At the last inspection in October 2014 improvements were needed in the recruitment practices. At this inspection we saw that improvements had been made to ensure staff's suitability to deliver care before they started work. Staff told us they were unable to start work until all of the required checks had been completed. We looked at the recruitment checks in place for three staff. We saw that they had Disclosure and Barring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions. The three staff files seen had all the required documentation in place, including confirmation of valid registration for nurses.

We saw that staff were available in communal areas and calls bells were answered promptly. People and their visitors did not raise any concerns regarding the numbers of staff available to support them. Staff we spoke with told us there were sufficient staff on duty to support people. One member of staff said, "We have enough staff to meet people's needs." The level of support each person needed had been assessed to determine the staffing levels required to support people.

Inadequate

Is the service effective?

Our findings

At the last inspection in October 2014 the rights of people who were unable to make important decisions about their health or wellbeing were not being protected. Staff were unsure about the legal requirements they had to work within to do this. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out these requirements that ensure where appropriate; decisions are made in people's best interests when they are unable to do this for themselves. We found that insufficient improvement had been made. Care records confirmed that people's capacity to make decisions had not been assessed. This meant these people's rights under the MCA were not addressed.

Where people were unable to consent, mental capacity assessments and best interest decisions had not always been completed. Staff confirmed that some people may lack the capacity to make certain decisions although they had not considered this. We saw, when needed, there was no capacity assessment in place to demonstrate people lacked the capacity to make their own decision. For example when taking medicine, there was no authorisation from the person's GP to confirm that this was agreed with them to be in the person's best interest.

Where capacity assessments were in place the information was limited and did not demonstrate that decisions were made in people's best interests or that people were supported to make decisions when possible. We saw that people's verbal consent was not always sought by staff before support was provided. For example one person's care plan stated that staff were to seek the person's consent prior to moving them. We saw the staff did not seek this person's consent before supporting them to move.

This is a breach of Regulation 11 (4) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At the last inspection in October 2014 improvements were needed to ensure people's nutritional needs were met. We found that insufficient improvement had been made. Staff's lack of understanding regarding people's nutritional requirements meant that people assessed as high risk of choking were put at risk. Although information was provided in people's care plans to direct staff, this was not followed. On Burton Court we observed staff did not follow guidance to ensure thickened fluids given were at the correct consistency. Guidance was not always followed regarding the rate that people were supported to drink and the supervision they needed after consuming a drink because their risk of choking was higher. One person's care plan provided information on the amount of fluids the person was able to swallow at any one time. We observed a member of care staff giving larger quantities of fluid to this person than directed in the care plan. We heard fluid in this person's throat which indicated that they were unable to swallow this amount of liquid being given. The member of staff then left the room, putting this person at high risk of choking. On Bridge Court one person was being given a drink that was detrimental to their health. We knew this because we had spoken with the dietician. We had to intervene to stop a member of staff from giving this person the drink.

One person living at Burton Court had been referred to the dietician in March 2015 who recommended a daily minimum fluid intake. We saw that no fluid monitoring intake was in place for this person. Staff told us this person did not require fluid monitoring as they drank plenty of fluids and there were no concerns. Staff were not aware of the dietician input which meant guidance was not being followed to ensure this person received the recommended fluid intake to maintain hydration.

This is a breach of Regulation 14 (4) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Our observations confirmed that some staff did not have the skills and competence to support people safely. As well as the lack of understanding regarding people's dietary needs we also observed unsafe practices for people that were supported with their mobility needs. For example we observed two care staff supporting a person on Bridge Court to transfer from a wheelchair into an arm chair. The sling used to transfer the person was put on the wrong way round, which meant the person's safety was compromised as they were not seated correctly. The care staff did not check that brakes were available on the wheelchair or that it was suitable. The person's feet were not on the foot rest but underneath the foot rest, putting their feet at risk of injury. We had to intervene to stop this manoeuvre as it was unsafe and was putting the person at risk.

Inadequate

Is the service effective?

We observed another person on Bridge Court being pushed in a wheelchair with their feet under the foot plates. This person's feet were being dragged along the carpet, which put them at risk of injury. When care staff were transferring this person in to other moving and handling equipment, we had to intervene as the person's feet were at risk of being trapped in the equipment being used.

Some staff we spoke with were unable to demonstrate knowledge and understanding of the training they received. For example two members of staff were asked about the dementia awareness training they had done. One member of staff was unable to offer any information. The other member of staff said, "I learnt we treat people as adults." This showed us that some staff did not have the knowledge needed to support people according to their needs.

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

There was evidence in care plans that people were on most occasions referred to health care professionals when needed. However, for two people that lived on Burton Court the acting manager was unable to produce evidence from the occupational therapist regarding the safety and appropriateness of chairs in use for people. On Bridge Court one person had been assessed by the tissue viability nurse six days before our inspection. From that assessment it was identified that this person needed to see the chiropodist. There was no evidence that this had been arranged. The manager was not aware that this was required and confirmed this had not been done. Staff had also identified a healthcare concern regarding this person and records stated that this had been reported to the nurse on duty. The manager was not aware of this health concern and there was no further evidence that this concern had been passed on to this person's GP or that any action had been taken. As identified earlier in this report we had concerns that people's medicines needed to be reviewed and staff confirmed this had not been done. However there had been no arrangement with GPs to do so. This put people at risk of not having their health care needs met.

This is a breach of Regulation 9 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw that some people were not always supported to eat their meal in a timely way. For example, on Bridge Court we observed one person was not supported to eat their hot meal until 30 minutes after it was served. We saw that this person ate only half of their meal.

People who were able told us they enjoyed the food provided. One person said, "The meals are very tasty, I enjoy most things. " We saw another person had requested an alternative to the choices available and they were provided with this.

Staff responsible for assessing people's capacity to consent to their care, demonstrated an awareness of the Deprivation of Liberty Safeguards (DoLS). We saw that people's rights were protected because Deprivations of Liberty Safeguards (DoLS) applications had and were being made.

Requires improvement

Is the service caring?

Our findings

Some people did not receive individual support to meet their needs. We saw a member of staff supporting more than one person to eat their meal, at the same time, on Bridge Court. At the same time we saw another member of care staff, sitting close to people waiting for support with their meal, doing paperwork. This demonstrated that staff did not prioritise their work to ensure people were supported in a timely way.

On several occasions another person indicated, by their body language, that they had eaten sufficient. The member of care staff ignored this and continued to spoon food into their mouth. This demonstrated a lack of respect for the person's wishes.

We observed two care staff, on Bridge Court, supporting people to transfer. Staff did not speak or engage with these people whilst they were moving them. This meant they did not offer reassurance during a manoeuvre which may make them feel vulnerable or unsafe.

On Bridge Court we observed that some people had stained their clothes whilst eating. Staff did not offer to support people to change into clean clothes which meant that people remained in stained clothing for the remainder of the day. This demonstrated that people were not supported to maintain their dignity.

This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Most staff interactions with people were kind and patient, one member of the care staff on Trent Court told us, "We have to be patient with people, they need us." We observed staff knocking on people's bedroom doors before entering rooms, which showed us they respected people's privacy.

We saw that staff supported people to make day to day choices where they were able. For example we heard staff asking people what they would like to drink and offering choices at meal times. This demonstrated that staff supported people to make decisions when possible.

We saw that independent mental capacity advocates (IMCA) were in place for some people to represent and support them in relation to their best interests. An IMCA is a type of advocacy introduced by the Mental Capacity Act 2005 (MCA). The MCA gives some people who lack capacity a right to receive support from an IMCA in relation to important decisions about their care.

Visitors told us they felt comfortable when they visited, as they were welcomed by staff and were free to visit at any time. This showed us that staff supported people to maintain contact with their family and friends.

Inadequate

Is the service responsive?

Our findings

Staff on Bridge Court told us that communication was poor and that the constant changes in management contributed to people receiving support that did not meet their needs. Comments from staff included, "The fluid charts have changed again today, every new manager wants to put their stamp on things. It is not helpful as we don't know why changes are made." And "Communication is poor, messages are not clear." We saw that people's experiences of care were task centred, rather than responsive to their individual needs and preferences.

We heard some staff, with limited understanding of the English language, struggling to converse effectively with people. We saw that one member of care staff on Burton Court could not understand people's requests or respond appropriately to them. This put people at risk of receiving care that did not meet their needs. A member of staff on Bridge Court told us, "Hospital visits can be difficult because some staff due to the language barrier can't convey information or understand what they are being told." This meant that changes that were important to people's well-being were not effectively communicated.

On Burton Court staff were not provided with clear direction on how to support people who demonstrated behaviours that put themselves or others at risk. We saw one person was agitated and appeared distressed for most of the day. Staff had clear information about the types of behaviour the person may display but no guidance about the techniques staff should use to alleviate this person's anxiety and agitation. The person's care plan directed staff to, 'use verbal de-escalation techniques' but provided no further detail to enable staff to support this person. We saw this care plan had not been reviewed since January 2014, which meant we could not be assured the information was up to date.

We identified the same findings observed at our last inspection in October 2014 regarding the support people received on Burton and Bridge Court. We saw that although information was recorded in care plans it was not always followed by staff to ensure people's needs were met. We spoke with visiting professionals and the information they offered demonstrated that the staff did not follow their recommendations. This led to people receiving care that put their health and well-being at risk, particularly around ensuring their nutrition and risks associated with swallowing difficulties were met.

This is a breach of Regulation 9 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Although we found evidence to demonstrate that care plans were not followed, visitors told us that they were involved in development of their relatives care. One person told us they were fully involved in all aspects of their relatives care. They confirmed that any changes in their relatives needs were discussed them.

The social and recreational support provided to people varied in each unit. On Burton Court we saw that staff interaction to support people's social needs was limited because there was no structure or planned activities. This did not ensure people's social needs were incorporated into their plan of care on a day to day basis. Staff told us there were no planned activities other than from the activities coordinator from Bridge Court once a week. We observed that some people were supported on an unplanned basis to engage in recreational pursuits by staff. For example one person was given colouring pencils and colouring books to use. A member of staff started a game of giant snakes and ladders with other people but the staff member left the room and people stopped playing. Although another staff member was in the room, they did not support people to engage with the game or continue playing.

On Bridge Court an activities coordinator was employed to provide social stimulation to people. We observed this person spending one to one time with people and encouraging people to participate in a ball game. The activities person told us that they were new and confirmed they were defining their role. We observed several people who spent the majority of their time walking around the communal areas. We asked a member of care staff if people were supported to access the local community and were told that they had been told that people were not to be taken out of the home by staff. Care staff we spoke to said there was not enough for people to do. One member of staff said, "We have enough staff but there isn't enough activities for people. There are no quizzes or games just

Inadequate

Is the service responsive?

throwing the ball or one to one with people." Another member of staff said, "There isn't enough stimulation." Our observations and these comments showed us that people's social needs were not fully met on Bridge Court.

On Trent Court we saw that people's individual needs were met and staff interacted well with people to support them. The staff worked well as a team to ensure people's needs were met. People were supported to participate in recreational pursuits that met their preferences and level of ability. We saw that staff supported people in a variety of activities both in the unit and in the local community. People had access to a secure outdoor area that provided seating, which meant that people were able to access this area independently. A games room was also available for people to use.

We saw that people were supported to maintain their religious beliefs. One person received a visit from their faith representative during our inspection. Information within people's records showed that they were supported to maintain links with their family and friends.

The manager overseeing all units told us that relatives meetings had been organised but there was poor attendance with only one relative attending the last meeting. This demonstrated that people's representatives were given opportunities to express their views.

People's visitors told us that if they had any concerns they would feel comfortable to raise them with the person in charge. People that we spoke with and their relatives were happy with the support provided and did not raise any concerns regarding the management of the home or the care provided to them. The provider's complaints policy was accessible to people so that they could express their opinion about the service. A system was in place to manage complaints. We saw there was a copy of the complaints policy on display in the home. Records seen demonstrated that complaints were responded to in a timely way.

Inadequate

Is the service well-led?

Our findings

There remained inconsistent leadership and direction for staff. There had been no registered manager in post since February 2014.This meant that staff had not received clear leadership and we saw that this impacted on the care people received, particularly on Bridge Court and Burton Court, putting some people at risk of harm.

We saw that information on whistleblowing was on display. However, we received comments from some staff at this inspection and before that indicated that they were not comfortable reporting concerns. Some staff told us that concerns reported to management would not be listened to and taken seriously. We received information that indicated that when staff had challenged practices they were made to feel uncomfortable by managers. We saw in the minutes of the most recent team meeting that a manager had advised staff to 'be careful what you say to people.' A member of staff we spoke with said this was in reference to staff raising concerns.

The staff told us that staff turnover was high and we saw that they were not adequately supervised. One member of staff told us that they did not receive sufficient feedback following time off work, to support people according to their needs. Although staff had received training we saw unsafe practices being undertaken and people were placed at risk.

This is a breach of Regulation 20 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw that people's fluid and dietary intake was recorded when needed and records showed the total intake for the day. However, on Bridge Court these daily records where then filed away every evening. This meant that staff could not review people's dietary intake over any length of time to ensure when people's intake was low it could be identified and actions taken. There was no evidence to show that the records filed away were monitored or reviewed.

Due to further changes in the management of the home the quality monitoring systems in place had not been undertaken in most areas over recent months. This meant that checks were not in place to ensure areas for improvement were identified and changes made as needed.

We looked at a mattress audit undertaken by staff at the home. The audits showed that the mattresses in place on people's beds were suitable. However, an independent audit commissioned by external professionals was undertaken shortly afterwards and identified there were several beds and mattresses that were not fit for purpose, some requiring repair and others requiring replacement. This demonstrated that the audits undertaken by staff were incorrect; meaning that staff either did not have the skills to assess mattresses or that mattress checks had not been undertaken.

Satisfaction surveys were not available to view and the manager was unsure when these were last sent out to people. The manager advised us they only received feedback from the provider when comments received in satisfaction surveys identified concerns. This meant that manager did not have an overview from satisfaction surveys to enable them to feed this back to people and their representatives and the staff team.

This is a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People were at risk of injury as some equipment in use was damaged. Other equipment was not in use as it had not been maintained. **Regulation 15 (1)**

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 Risk assessments were not always followed or consistent to ensure people received safe care. **Regulation 12 (2) (a)**

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 protected from abuse because the staff's competency in identifying abuse was limited. **Regulation 13 (2**

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 A person not subject to control or restraint did not have their rights protected. This was because their movements were restricted, which was not a necessary or a proportionate response to the support being provided to them. **Regulation 13 (4) (b)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

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 Safe systems were not in place to ensure people's needs regarding certain PRN medicines were being met. People's pain relief was not managed to ensure they were comfortable and pain free. **Regulation 12 (2) (g)**

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 Where people were unable to consent, mental capacity assessments and best interest decision had not always been completed. Staff did not always seek people's verbal consent before supporting them. **Regulation 11 (4)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People's nutritional requirements were not being met and their health was put at risk. **Regulation 14 (4)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not have the knowledge needed to support people according to their needs. **Regulation 18 (2)**

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 People were at risk of not having their health care needs met, as referrals to professionals were not always made when needed. **Regulation 9 (1)**

This section is primarily information for the provider

Action we have told the provider to take

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 People were not always supported to maintain their dignity. Some staff practices demonstrated that people were not always treated in a respectful way because some staff did not communicate effectively with people whilst providing support. **Regulation 10 (1)**

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 People's care plans were not always followed by staff to ensure people's needs were met. Staff were not always provided with clear direction on how to support people according to their needs.**Regulation 9 (1)**

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 leadership and culture of the home did not encourage openness and honesty at all levels. This impacted on the care people received putting some people at risk of harm. **Regulation 20 (1)**

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 and processes in place were not operated effectively to assess, monitor and improve the quality and safety of the services provided. This put people who used the service at risk of poor care. **Regulation 17 (1) (2)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have effective governance, to enable them to mitigate any risks relating the health and safety of people that used the service.

The enforcement action we took:
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.