Astracare (UK) Limited

Harvey Centre - Mental Health Nursing Home

Inspection report

19-23 The Street
Weeley
Clacton On Sea
Essex
CO16 9JF

Tel: 01255831457

Date of inspection visit:
16 February 2017
21 February 2017

Date of publication:
17 May 2017

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The Harvey Centre is an 18 bedded nursing home for people living with mental health illnesses. There were 8 people in the service when we inspected on 16 and 21 February 2017. This was an unannounced inspection.

The service is attached to Connolly House hospital, also provided by Astracare (UK) Limited. Both services are governed by the same management team. The majority of people living at the Harvey Centre had first received treatment at the hospital.

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

Despite assurances and an action plan stating that improvements would be made following our last inspection in May 2016, the provider had failed to establish effective systems and processes to assess, monitor and improve the quality and safety of the service, to ensure people receive safe and effective care.

The inappropriate management of people's medicines placed them at risk of harm. People were not protected from the risks associated with the unsafe management of food and ineffective cleaning regimes. The provider had failed to take the necessary actions to ensure that the risks to the health and safety of service users were assessed, mitigated and reviewed appropriately.

Although improvements were seen in some people's care plans they remained inconsistent and lacked sufficient detail in some areas. Despite the shortfalls within people's records, people told us that they received personalised care which was responsive to their physical needs.

Activities remained task focussed and there remained a lack of opportunity for people to engage in meaningful activity outside of the planned provision. People lacked opportunities to make an informed choice about their meals and were not always effectively supported with their nutritional needs.

Staff understood the importance of gaining people's consent and were compassionate, attentive and caring in their interactions with people. They understood people's preferred routines, likes and dislikes and what mattered to them. People were involved in making decisions about their care.

There were enough staff to meet people's needs and procedures were in place to safeguard people from the potential risk of abuse. Concerns and complaints had been investigated, responded to, and appropriate action taken.

Staff were trained and received regular supervision however training was limited in assisting staff to meet the specific needs of people living with dementia.

The lack of oversight from all levels of management meant improvements were not being properly implemented, monitored or sustained. This resulted in continued non-compliance with regulations and poor outcomes for people. We recommend that the provider consult current best practice guidelines for the provision of dementia care

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Commission is considering its enforcement powers.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service 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 than12 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.

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.

The inappropriate management of people's medicines placed them at risk of harm

People were not protected from the risks associated with the unsafe management of food and ineffective cleaning regimes.

Not all potential risks relating to people's care and support needs had been identified and effective control measures put in place.

There were enough staff to meet people's needs.

Procedures were in place to safeguard people from the potential risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People lacked opportunities to make an informed choice about their meals.

People were not effectively supported with their nutritional needs.

Staff were trained and received regular supervision however training was limited in assisting staff to meet the specific needs of people living with dementia.

Staff understood the importance of gaining people's consent and were knowledgeable in The Deprivation of Liberty Safeguards.

People had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider had not ensured the service was being run in a manner that promoted a caring and person centred culture.

Staff were compassionate, attentive and caring in their interactions with people.

People were involved in making decisions about their care.

Staff understood people's preferred routines, likes and dislikes and what mattered to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although improvements were seen in some people's care plans they remained inconsistent and lacked sufficient detail in some areas.

Despite the shortfalls within people's records, people told us that they received personalised care which was responsive to their physical needs.

Activities remained task focussed and there remained a lack of opportunity for people to engage in meaningful activity outside of the planned provision.

Concerns and complaints had been investigated, responded to, and appropriate action taken.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to take the necessary actions to ensure that the risks to the health and safety of service users were assessed, mitigated and reviewed appropriately.

The provider had failed to establish effective systems and processes to assess, monitor and improve the quality and safety of the service.

The lack of oversight from all levels of management meant improvements were not being properly implemented, monitored or sustained. This resulted in continued non-compliance with regulations and poor outcomes for people.

Harvey Centre - Mental Health Nursing Home

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 unannounced inspection took place on 16 and 21 February 2017. The inspection team was made up of one inspector, a specialist advisor who had knowledge and experience in mental health care and a pharmacy specialist.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with four people who used the service, two relatives and a health care professional who was visiting the service. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the registered manager, director, assistant director and estate and non-clinical manager. We also spoke with the activities co-ordinator and six other members of care and kitchen staff.

To help us assess how people's care and support needs were being met we reviewed eight people's care

records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

The inappropriate management of people's medicines placed them at risk of harm. At our last inspection we found breaches in regulation about how the provider was protecting people against the risk of unsafe care. At this inspection we found there were no protocols in place for medicine prescribed to be taken 'as and when required' (PRN) to guide staff as to how and when these should be administered. These protocols had still not been introduced. This meant that staff may not be aware when a person needed medicine such as pain relief because there was no guidance to show how people communicated that they were in pain when they were unable to verbalise how they were feeling.

At our last inspection we also found there was a lack of guidance relating to medicines administered covertly. At this inspection we found this was still the case. We could not find evidence that supported which medicines had been agreed to be given covertly and how these were to be administered accurately. This meant that there was a potential risk people may not receive their medicines as they had been prescribed in a way which would not compromise their safety or effectiveness.

The management team acknowledged that work was still needed in relation to PRN medicines and covert medicines and following the inspection demonstrated to us how they planned to ensure these were appropriately managed going forward.

At this inspection we also found further significant shortfalls in the management of peoples medicines.

There were 28 occasions in the last month where medication administration records (MAR) indicated that people had not received their medicines as prescribed; this included an antibiotic for one person where only 11 of the 21 prescribed doses had been recorded as given. Other medicines that had been missed included a mucolytic, mood stabiliser, antipsychotic, laxatives, eye drops and food supplements. In one case where an out of hours doctor had visited, a preparation for oral thrush should have been started but hadn't been recorded on the MAR chart or treatment chart. We could therefore not be assured that people were receiving all of their medicines as prescribed.

One person was receiving a strong painkiller via a patch applied to their skin but there was no pain relief prescribed for any breakthrough pain should it be required. There was also no care plan in place for the management of this person's pain.

Medicines that were applied as patches were not being recorded appropriately. The site of administration was not being recorded in order to ensure rotation of the patches occurred as recommended by the manufacturer. Where people were prescribed topical medicines there was no guidance to advise staff as to where to apply these and no documentation to demonstrate that this had been done.

One person's care plan indicated that they were at risk of choking due to swallowing difficulties and therefore required all fluids to be thickened appropriately. However a liquid medicine was being administered on a spoon without being thickened. A thickener preparation was not prescribed on the

person's medicine record and there was no mention of how to administer their medicines in their care plan. This put the person at risk of significant harm should they choke when taking this medicine.

Medicines requiring cold storage were kept within a refrigerator in the treatment room. However the temperature of the refrigerator was not accurately monitored and it was therefore unclear whether these medicines had been consistently kept at the correct temperature in order to ensure they remained effective and safe to administer. We discussed this with the management team who agreed a new system was required to ensure accurate monitoring. This was implemented on the day of our inspection.

The provider had failed to take the necessary actions to ensure that service users and others were protected from the risks associated with the unsafe management of food and ineffective cleaning regimes.

Records showed that the temperature recorded for one freezer was at times higher than the required minimum temperature, as advised by the food standards agency. Kitchen staff were unable to tell us what the temperature should be and whether any action had been taken on the days it was too high. The cleaning schedule for the kitchen had not been completed in six out of 21 days in the past month. The cook explained that this was due to a new member of staff being unaware of the procedures but it was unclear whether or not the cleaning had been carried out. Core temperatures had not been taken of over half of the meals prepared. This meant that staff could not be assured that all hot food was being heated to the required temperatures to ensure that it was safe to eat, putting people at risk of harm.

At last inspection we found that people were not adequately protected against the risk of acquiring a pressure ulcer. There remained some inconsistency in pressure care records. The risk assessment for one person showed that they needed to be repositioned every two hours but their care plan stated a need to be repositioned every four hours. The chart used to record repositioning did not show how frequently repositioning was required. Without clear guidance staff could not be sure they were providing support in line with the recommendations from the community nursing team placing the person at increased risk of acquiring a pressure ulcer.

People were not always protected from the risk of falls. Records for three people showed they were at risk of falling from their beds. Although crash mats and sensors were in place, the use of bed sides as a way of preventing a fall had not been considered. The registered manager told us that bed rails were, "not allowed" and this was confirmed by the assistant director. The failure to stay up to date with current best practice guidelines meant that an effective control measure such as bed sides had not been considered, along with appropriate risk and capacity assessments, as a way of reducing the risk of falls from bed. People's risk assessments had not been updated following falls to show how they may now be at risk. This meant that appropriate control measures had not been considered which put people at potential risk of harm.

There was no tool in place, such as the Malnutrition Universal Screening Tool (MUST) to assess people's risk of malnutrition. The manager explained that no one was currently at risk but it was unclear how this had been assessed. One person's care plan indicated that they were at risk of malnutrition but without the use of an appropriate screening tool there was a risk that this would not be effectively monitored and additional nutritional support provided when needed. The cook told us that no one was at risk of malnutrition and lacked knowledge regarding the practice of fortifying foods if needed.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in May 2016 there were mixed views about whether there were sufficient numbers of

staff to care for and support people according to their needs. At this inspection people were more confident that there were enough staff on duty. There were now less people living in the service and two people told us that they did feel there were enough staff. A relative commented, "There has never been any problem with the amount of staff on." Staff continued to have mixed views and whilst one told us, "There are definitely enough staff. If there are any shortages they get in agency." Another staff member said, "Sometimes they [staff] don't turn up. If [staff] have not turned up it can be short. Sometimes if we are really short they'll get someone from the other side [Connolly House]." On the second day of our inspection the registered manager was acting as nurse in charge because a member of staff had called in sick. This demonstrated that although adequate staffing numbers were usually maintained, senior members of staff were sometimes taken away from their usual role which had a detrimental effect in that they were then unable to achieve the level of oversight needed.

People presented as relaxed and at ease in their surroundings and with the staff. A person told us, "I feel safe and secure in here."

Systems were in place to reduce people being at risk of potential abuse. Staff had received up to date safeguarding training and knew how to recognise and report any concerns. A member of staff told us, "We have a [reporting] line, I'd go to the nurse, [registered manager], [assistant director]. [Director] is available 24/seven and obviously you can get in touch with the [local authority] safeguarding team." Another staff member explained, "They've given us a phone number. It's in the office." This meant that staff had access to the relevant contact details for the appropriate professionals who were responsible for investigating concerns of abuse.

Risks to people injuring themselves or others due to premises or equipment were limited because there were maintenance and service contracts in place to ensure the premises was well maintained and safe. Equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire. There was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary.

Recruitment records showed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that people lacked choice around the times that their food was served at mealtimes and had little opportunity to change their minds. There had been some improvement in that people were now asked what they would like the day before it was served and a picture menu was now available to aid them in making a decision. However, this was still not an effective way of offering people choice as the cook told us that many people wouldn't be able to remember what they had requested. There was still limited opportunity for people to change their minds as only the required amount of each dish was prepared. Food arrived from the main kitchen already plated up with no opportunity for people to decide how many vegetables they would like or ability to add the amount of gravy/sauce they preferred. At lunchtime no choice of drinks was seen to be offered. On the first day of inspection the menu board did not reflect what a member of staff told people was for lunch and was also different to what arrived to be served.

There was little provision for meals required at alternative times or additional snacks throughout the day if required. A member of kitchen staff commented, "They shouldn't be hungry, the portions are big. Biscuits are available." This demonstrated that there were limited opportunities for people to be involved in their choice of meals and snacks and choices were limited if they wished to have these at times outside of the normal mealtime routine.

It was not clear how people were effectively supported with their nutritional needs. Care plan records were inconsistent with kitchen records in relation to people's dietary needs. One person's care plan indicated in parts that they were diabetic and in the kitchen diabetic options were ticked on menu choices for this person. However, the kitchen records also said that this person was on a normal diet and the registered manager told us that this person was no longer considered to be diabetic. Another person's care records stated that there were no dietary considerations or problems in relation to their health which would affect their ability to eat a normal diet. However, elsewhere in their care plan it said the person sometimes spat out food. The conflicting information meant that it was unclear to staff how they should be supporting people with their dietary needs.

Issues had been identified for some people such as difficulty swallowing. Guidance and support had been sought from health care professionals, including dieticians and speech and language therapists. However, there was no tool in place, such as the Malnutrition Universal Screening Tool (MUST) to assess people's risk of malnutrition. The manager explained that no one was currently at risk but it was unclear how this had been assessed. One person's current BMI and care plan indicated that they were at risk but without the use of an appropriate screening tool there was a risk that this would not be effectively monitored and additional nutritional support provided when needed. A member of kitchen staff told us that no one was at risk of malnutrition and lacked knowledge regarding the practice of fortifying foods if needed. This meant that staff were not provided will all the information they needed to ensure that they were meeting people's nutritional needs appropriately.

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

Staff were provided with a range of training to assist them to meet people's needs and preferences. A member of staff commented "There is always something going on. They are quite hot on training." However, training in dementia care was limited and our observations told us that this had not been completely effective in providing staff with the knowledge and understanding they needed in relation to the specific needs of people living with dementia. Staff were not provided with the resources they needed to provide a holistic approach to care whereby all aspects of people's physical, emotional and psychological needs were met. For example, there seemed to be little available to aid reminiscence or sensory stimulation to enable staff to meet people's needs more effectively.

At our last inspection in May 2016 we found that one to one staff supervision's were not taking place regularly. At this inspection we found that there had been improvements with this. A member of staff told us, "I have my supervision with one of the nurses. I also supervise some of the healthcare assistants. If they have any concerns they can come to me or the nurse in charge any time." The assistant director showed us that there was now a more structured system in place to ensure staff were given the opportunity to talk through any issues, seek advice and receive feedback about their work practice.

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 helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. Mental capacity assessments had been undertaken in relation to DoLS and were also in place where people lacked capacity to make other decisions, such as about their daily routines and use of the call bell.

We observed that staff sought people's consent before providing support or care and acted in accordance with their wishes. A member of staff told us how they went about finding out how people would like to be supported, "Not all of them can make a decision but we still ask them. Their 'My Chart' shows what they like." The 'My Chart' for each person provided staff with key information about them, their preferences, like and dislikes and what was important to them.

People had access to health care services and received on-going health care support where required. A GP visited the service twice a week and we saw records of visits to health care professionals in people's files. One person's care records showed that staff had noted that their blood pressure had dropped and arranged for the GP to pay an additional visit. This showed that staff were aware of people's routine health needs and involved health and social care agencies when additional support was required to help people stay well.

Requires Improvement

Is the service caring?

Our findings

Although people said staff were caring and kind, the provider had not ensured the service was being run in a manner that promoted a caring and person centred culture. For example, the inconsistency of care records and task focused approach to people's daily living meant that staff had not been equipped with the appropriate knowledge and resources to enable them to provide individualised care with a holistic approach to ensure people's whole well-being.

At our last inspection in May 2016 we found that care plans had not been regularly updated. It had therefore not been clear whether these records reflected people's current preferences, likes and dislikes. At this inspection we found that there were improvements in this. 'My Chart' documents gave staff an overview of each person and what was important to them including what activities they enjoyed, what food and drinks they liked and disliked and what they liked to wear. One person's care records indicated that their next of kin was to be involved in all care and treatment. This person liked music however they were no longer able to verbalise this for themselves. Their relative told us, "We asked that he always has his music on and he always does." This demonstrated that people and their families were involved in informing staff what was important to them.

At our last inspection we found that although people's opinions had been sought about their care and support it was not clear whether these had been acknowledged and acted on. At this inspection we found that people and their families had been involved in planning for their future care provision. The contract with the local Clinical Commissioning Group (CCG) who provided funding for people living at the service was due to end at the end of March 2017. This meant that alternative places to live needed to be found for everyone living at the service. A visiting healthcare professional told us how people had been involved in these discussions and we observed that people were encouraged by the registered manager to attend the meetings in relation to these decisions. A relative told us how they had also been involved and commented, "They've [Registered manager has] been really good and kept us informed all the way through."

Staff were aware of the need to respect people's privacy and dignity for the majority of the time. A member of staff said that they, "Respect [people's] privacy during personal care. Keep doors shut, tell them wat is going to happen and give encouragement." They added, "I'd rather treat a person like my mum or dad." However, at lunchtime three people on one table were given a disposable blue plastic apron to wear. There appeared to be no other alternative available should people prefer a different method of protecting their clothing, One person's care plan said staff should, 'encourage [person] to wear a blue apron to protect [their] clothes and promote dignity'. We discussed with the management team whether the universal use of disposable aprons was dignified and talked about other positive alternatives which people may choose to use instead if they were available.

People were positive and complimentary about the care they received. One person told us that staff were, "wonderful". Another person said, "The staff are very nice." And went on to tell us, "When I first came here I couldn't have had this conversation. My memory has slowly come back." A family member commented, "We really can't fault the care [person] gets here."

Staff demonstrated empathy, understanding and warmth in their interactions with people. For example, we observed one person being assisted to move into their wheelchair using the hoist. The staff took time to explain to the person what was happening and offered reassurance throughout the process, "We're going up, lovely, excellent. We're going round now, going into your wheelchair, alright?" The person appeared to be relaxed with the staff and appreciative of the reassurance given.

Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. A person told us that they felt staff knew them well. A relative said, "They know the sort of thing he likes, music and singing they've always involved him in that." A member of staff explained how they found out more about what was important to people, "You can tell by [people's] faces [what they like or dislike] When you have a good rapport with relatives you can chat with them and they tell you things you need to know."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found care plans had not been consistently updated to reflect people's current care needs. They were task focussed and lacked a holistic approach to ensure people's general well-being. Although improvements were seen in some people's care plans and they were now reviewed more frequently, they remained inconsistent and lacked sufficient detail in some areas, particularly in relation to the specific needs of people living with dementia. For example, one person had been diagnosed with a specific type of dementia; however there was no mention of this in the main body of the care plan or guidance for staff regarding what this meant for the person and how they could best be supported.

Other care plans had not been fully updated to reflect current care and support needs, for example it was unclear whether or not one person had diabetes. Another person had previously been receiving care and treatment for a specific health condition but it was unclear why this was no longer the case and how this now impacted on their care. Without clear guidance about peoples current support needs staff could not be sure that they were providing consistent, effective and safe care. There was also a risk that staff may not recognise and respond to changes in people's needs if it was unclear what their usual physical and mental state of health was.

At our last inspection we found that staff lacked understanding and appropriate resources to support people with physical or mental stimulation appropriate for people living with dementia or other mental health conditions. The majority of activity took place in a designated area for therapeutic activities which was referred to as the 'Day Centre.' However, there had been limited opportunity for general activity and mental stimulation for much of the day. There had been some improvements in the provision of activities in that an additional activities co-ordinator had been employed and time had been made for them to assist staff in providing activities in the main part of the service. There was also an arrangement where games and other activity resources were provided from the day centre between the hours of 9am and 5pm each day.

However, the provision of activities remained task focussed and there remained a lack of opportunity for people to engage in meaningful activity outside of the planned provision. There was very little in the way of stimulation for people other than what was provided by the day centre. A person told us, "I like going over to what we call the other side [day centre]. I listen to music sometimes have a quiz, they have chess and draughts. I like going over there." They added, "We have to go over there [day centre] for it. "The main lounge was sparse and lacked any resources readily available for people to engage in at a time of their choosing throughout the day. We spoke to a person watching television in the lounge and asked them what they had planned for that afternoon. They replied, "Not a lot." We asked if they liked watching what was on the television, they replied, "No. not really." Another person told us that earlier that day, "We had a quiz, it kills a bit of time you know." They seemed unsure of what else was available for them to do for the rest of the day. A modern radio station was playing in the conservatory where some people spent much of their day. This was despite a member of staff telling us that people preferred older styles of music. One person told us, "They [staff] just choose it [music]"

People were supported to go for walks outside of the service and we saw that one person went out for a

short while with a member of staff on the second day of our inspection, however records did not reflect that this was a regular occurrence and people told us that they were not able to go out as often as they would like. One person said, "I don't get out so much from here. We get the chance to go to the local pub every now and again. Once in a while when there is a carer to take us."

The lack of meaningful activity demonstrated that there was still not a holistic approach to people's care and support to ensure their general wellbeing.

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

Staff continued to use 'The Care Programme Approach (CPA)' which is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health needs or a range of related complex needs. People who were part of this programme were supported by care co-ordinators who had carried out an assessment of their needs. This was reviewed annually and we saw that people had been involved in these reviews together with their families. However some of the details contained in the CPA reviews had not been included in the main care plan such as details about the type of dementia people had been diagnosed with and how this may impact on their support needs.

Despite the shortfalls and inconsistencies within people's records, a relative told us that staff were, "Responsive to any changes" and kept them well informed regarding any changes in their relative's health, "The slightest thing they call us." Some care plans did now contain more detail about how they could be supported with their emotional needs and how best to support them with any mental health concerns they may have. A member of staff told us, "Each person has their own individual needs. The files are a lot better than they were. If needs change you let the nurses know and they will change it." One person's care records gave detailed guidance of how they could be supported when they became unsettled and their behaviour became challenging. Information was given about possible triggers to help staff to recognise and respond to changes in their emotional state. Records had been completed showing how an incident had been responded to appropriately so that a potential challenging situation had been de-escalated and the person had received the support they needed

There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. A relative told us about a concern they had previously raised about an item not being properly cleaned each time it was used. They felt that they had been listened to and appropriate action had been taken. They commented, "We spoke to the staff and we've never had to bother them about it since." Records showed that there had been no formal complaints since December 2015 and details of any concerns raised showed that they had been investigated, responded to and appropriate action taken.

Inadequate

Is the service well-led?

Our findings

Despite assurances and an action plan stating that improvements would be made following our inspection in May 2016, the provider had failed to establish effective systems and processes to assess, monitor and improve the quality and safety of the service, to ensure people received safe and effective care.

The absence of effective monitoring or auditing meant that issues relating to people's care and treatment were missed and risks of potential harm were not being mitigated as far as possible. For example, there was no record of any medicines incidents being reported in the last six months even though we had found multiple omissions on the MAR and treatment charts. Medicines audits had failed to identify errors or areas where current best practice was not being followed, such as the absence of PRN protocols or the covert administration of medicines.

The provider had failed to take the necessary actions to ensure that the risks to the health and safety of service users were assessed, mitigated and reviewed appropriately. This included taking the necessary actions to ensure that service users and others were protected from the risks associated with the unsafe management of food and ineffective cleaning regimes.

Identified risks to people who use the service were not being effectively monitored and appropriate action taken without delay where a risk has increased. Care plans and risk assessments did not always contain accurate information. For example, in relation to the risk of malnutrition, falls or pressure ulcers. This resulted in the quality of care and safety of people using the service being compromised.

On the second day of our inspection the registered manager demonstrated that work had begun on addressing some of the concerns we had raised. However, the provider's audits had been ineffective in independently identifying on-going concerns. Without this oversight the provider had failed to ensure that improvements had been embedded and sustained and were unable to demonstrate that future shortfalls would be identified, appropriate action taken and lessons learnt.

The management team were also unable to demonstrate up to date knowledge around best practice for care providers and lacked effective systems for keeping informed on these matters independently. For example, in relation to the current guidance regarding the use of bed sides, requirements relating to managing medicines and guidance in providing appropriate support specific to the needs of people living with dementia.

The management team informed us during the inspection of their plans to de-register the adjoining hospital, Connolly House, and develop the Harvey Centre to become a specialist mental health nursing home with an emphasis on caring for people living with dementia. The way in which support was being provided at the time of our inspection did not align with these aspirations.

We recommend that the provider consult current best practice guidelines for the provision of dementia care from organisations such as the Alzheimer's Society, University of Stirling and National Institute for Health

and Care Excellence (NICE)

Although staff told us that the management team were approachable and a visiting healthcare professional commented that they were, "Very accommodating," there was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met.

The lack of oversight from all levels of management meant improvements were not being properly implemented, monitored or sustained. This resulted in continued non-compliance with regulations and poor outcomes for people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014