Sunrise Care Homes Limited

The Mount Residential Home

Inspection report

The Mount, Heydon Road
Aylsham
Norwich
Norfolk
NR11 6QT

Tel: 01263734516

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

Summary of findings

Overall summary

This inspection took place on 3 and 5 July 2017 and was unannounced.

We had previously inspected the service in August 2016 and had identified six regulatory breaches. These related to safeguarding people from harm, staffing arrangements, dignity and respect, person-centred care, the governance of the service and the requirement to report incidents to the Commission.

This July 2017 inspection identified seven regulatory breaches, five of which the provider had been in breach of from the August 2016 inspection. These repeat breaches related to safeguarding people from harm, staffing arrangements, person-centred care, the governance of the service and the requirement to report incidents to the Commission. The provider was no longer in breach of the regulation relating to dignity and respect. However, they were also now in breach of regulations regarding safe care and treatment and consent. You can see what action we told the provider to take at the back of the full version of the report.

The Mount Residential Home provides accommodation and support to a maximum of 22 men who have mental health needs and/or dementia. At the time of this July 2017 inspection, there were 19 men living in the home.

There was no registered manager in post. The manager of the home had been in post for approximately eight weeks. They told us that they had commenced the process to apply for registration. 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 main partner in the business (referred to as the provider in this report) was at the home most days during the week. They completed most of the care plans. The deputy manager oversaw the management of people's medicines and was responsible for health and safety checks and related maintenance of the home. The manager oversaw the general day to day operation of the home.

We found that incidents taking place between people living in the home that required reporting to the local authority's safeguarding team were not always reported. This meant that the local authority was unable to accurately determine whether people living in the home were at risk or would benefit from the input of health professionals. The service had not reported a safeguarding incident to the Commission in over two and a half years.

The provider was not clear about how many staff were required to support people during day. We had previously been told on two occasions that four staff were required. However, staffing levels fell below this, particularly at weekends. Staff training was considerably behind, but some training had been arranged. However, there was little training in place for staff in relation to people's mental health emotional needs.

Risks to people's health were not always identified. When they were identified the service did not always take appropriate actions to minimise the risks to people's welfare.

There was limited understanding and application of the Mental Capacity Act other than at a basic level. Where significant decisions needed to be made assessments had not been carried out appropriately.

People's care plans did not contain accurate, up to date or clear information for staff to help ensure that they provided a high standard of care and support to people.

The provider's auditing system was not robust and had not identified the concerns we found during this inspection. The provider had not made significant improvements since the August 2016 inspection.

People received their medicines as prescribed. The staff were kind and considerate and people were comfortable in their company. Most people felt involved in decisions relating to their care. Staff told us that morale was improving in the home. However, the frequent change in managers over the last 12 months had meant that plans to make improvements had not always come to fruition.

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.

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.

Risks to people's welfare were not always identified. When they were identified suitable actions were not always taken to help minimise them.

Safeguarding incidents were not always identified or reported to the local authority. People's freedoms were sometimes restricted.

Staffing levels and the deployment of staff was not always sufficient.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was limited understanding or practical application of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards when significant decisions needed to be made.

Staff training did not ensure staff had the knowledge and skills they needed to support people effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some practices in the home did not support people's dignity or independence.

People were supported by caring staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not contain clear instructions for staff to follow

which meant that people may not have received appropriate care.

People felt able to raise concerns about their care or support.

Is the service well-led?

Inadequate

The service was not well led.

The systems to assess the quality of the service provided were not always effective. Action was not always taken when areas for improvement had been identified.

Notifications were not made to CQC when safeguarding incidents occurred.

The Mount Residential 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 checked 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 3 July 2017 and was unannounced. The inspection was carried out by two inspectors on 3 July 2017 and completed by one inspector on 5 July 2017.

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

Prior to this inspection we liaised with the local authority's safeguarding and quality monitoring teams and we reviewed information held about the service. This included statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During this inspection we spoke with seven people living in the home and relatives or friends of four people. We also spoke with four care staff members, the manager, the deputy manager and the provider.

We made general observations of the care and support people received at the service. We looked at the medication records of three people living in the home and care records for seven people. We viewed records relating to staff recruitment as well as training and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection in August 2016 identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not take appropriate steps to report incidences of abuse to the local authority's safeguarding team. Systems in place to support people with their finances were not robust.

This July 2017 inspection found that some progress had been made. Receipts were in place in relation to items purchased on behalf of people. We sampled the financial arrangements in place for three people and found them to be in order.

From records we reviewed we noted that six incidents had occurred between people living in the home that needed to be reported to the local authority's safeguarding team. Records showed that only three of these incidents had been referred to them. The safeguarding team confirmed that the other three incidents had not been reported to them.

Training records showed that only 28% of staff had received up to date training in safeguarding. For nine staff members there was no record to show whether they had received this training. For another nine staff, their training was out of date.

Consequently, the provider was still in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our August 2016 inspection also found that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing. In August 2016 there had been 19 people living in the home. We were told at the time that that four care staff were required to meet people's needs during the day, but 11 shifts in the preceding eight weeks had been short staffed.

In December 2016 we corresponded with the then manager following concerns raised with us about staffing levels. They had advised that there were 17 people living in the home at the time and that four care staff were required during the day.

At this July 2017 inspection there were 19 people living in the home. The provider told us that they did not utilise a staffing calculation tool based on people's dependency levels. They told us that staffing levels were determined based on staff experience, whether outings had been arranged for people and by taking staff views into account.

We reviewed rotas for a four week period. There were 13 day shifts where three care staff had been on duty. The shortages were more notable at weekends.

People in the home felt that there was enough staff. However staff members did not agree. One told us, "There's not enough staff to ensure that people are able to go out and do things." A second staff member

told us, "We need five staff on during the day." One relative told us, "It's very busy here at weekends. There's not enough staff on then quite often."

Consequently, the provider remained in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate steps were taken to minimise the risks of employing staff unsuitable for their role. We reviewed staff recruitment records for three recently recruited staff. References were obtained and checks were carried out with the Disclosure and Baring Service (DBS) to ensure that prospective staff were not barred from working in the care sector or had criminal records that would prohibit their employment.

Risks to people's wellbeing were identified and risk assessments were in place. However, suitable actions were not always taken to reduce the risks to people. One person had been assessed by a community nurse as needing a pressure mattress for their bed to help alleviate the risk of skin breakdown. We found that the mattress was in its container in the person's room. Another person had experienced five falls in 2017. However, this had not been identified as a concern requiring the input of health professionals or other interventions to help reduce the amount of falls.

Nutritional risks were not always appropriately acted upon. One person's recent nutritional risk assessment scored them as at high risk of not eating enough due to decreasing weight. Whilst the service had referred the person's weight loss to the person's GP, there had been no plan of action within the home to support the person nutritionally.

Another person was weighed monthly. We found that their last recorded weight had shown an 8kg decrease in the space of a month. This had not been noted upon or investigated at the time. We asked that the person was re-weighed during our inspection. This was done and the 8kg weight loss was found to have been incorrect. However, had this been a genuine weight loss then the person would not have received prompt or appropriate support with their welfare as the weight loss had not been queried.

Incident reports were not consistently reviewed by the manager to ensure that appropriate actions had been taken in response to the incident or that the causes were investigated to help prevent a re-occurrence of events.

We observed in some communal bathrooms that razors had been left at the sinks. The home cared for people with mental health conditions. The provider told us that they did not consider people living in the home to be at risk of self- harm. However, there was the potential for cross contamination if people used other people's razors. Mops were sitting in buckets of fluid in all toilets and bathrooms. This was not in accordance with good infection control practice. There was the additional risk of these being knocked over when spillages could cause people to slip on the wet flooring.

These concerns meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living in the home. Most relatives and friends also felt that their loved ones were safe living in the home.

Appropriate checks were made to ensure that the premises were safe. Equipment was regularly serviced and utilities were inspected for safety.

The provider was unable to demonstrate that arrangements were in place to ensure that people were involved in decisions about any risks they might wish to take, for example, in relation to the consumption of alcohol. One person's freedoms were being restricted because the service had not supported the person with their independence, in accordance with conditions on their Deprivation of Liberty Safeguards (DoLS) authorisation.

The arrangements in place for managing and administering people's medicines were robust. Some staff had been trained by a diabetes specialist nurse to administer insulin to people. We saw that that staff had received recent training for this and had been periodically tested and signed off as competent by the nurse before they were able to administer insulin to people.

Some people were prescribed medicines on a 'when required' basis. We saw that guidance was available in respect of each such medicine to enable staff handling and giving people their medicines to do so safely and consistently. Records included pictures of people for personal identification and information about known allergies and medicine sensitivities. People's medicine administration record (MAR) charts were fully completed. If someone did not take a medicine the reason for this was recorded.

The temperature of the medicines fridge and the corridor where the medicines trolleys were kept were recorded. Both records showed that these were at suitable temperatures. The deputy manager told us that the temperature for the corridor was taken at around 7am each day. Records showed that recent temperatures varied between 21 and 23 degrees Celsius. The trolleys were in a corridor with lots of windows. We were concerned that later in the day the temperature could exceed 25 degrees Celsius. The deputy manager told us that they would look into this and would take any necessary actions if the temperatures were too high.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. We found concerns in both these areas.

One person's records showed that they consumed a certain level of alcohol a week. Staff told us that this was not correct as following health professional advice the person was able to have a restricted amount of alcohol per day. The person told us that that their access to alcohol had been restricted, but that they had not consented to this.

Where mental capacity assessments had been carried out the records were not always clear about what the decision was that needed to be made. There was no clear assessment of people's abilities to understand what the decision was that needed to be made, the consequences of any decision made or whether people could retain, use and weigh up the information relevant to the decision. Comments made in these assessments were of a general nature and not linked to the decision needing to be made.

One mental capacity assessment determined that the person had capacity to make their own decision on a matter. However, a best interests record had been made. This was not required where the person is able to make their own decision. We were not satisfied that robust assessments of people's capacity were being made.

We looked at authorisations for DoLS applications made in relation to two people to see whether conditions of the authorisations had been adhered to. Conditions on one person's authorisation stated that opportunities should be made to take the person into the community and assess their orientation and ability to function. This had not been done. The person told us that they wanted to be more independent but was not given a chance.

These concerns meant that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw that people were encouraged to make decisions about their care and their

day to day routines and preferences.

The staff training records showed that less than 50% of staff had undertaken training in food hygiene, health and safety, mental capacity/DoLS and safeguarding. Six staff required moving and handling training.

The home cared for people with mental health conditions, several of whom also had dementia. Some people living in the home would, on occasion, exhibit challenging behaviour. There was little training for staff in these areas. 21% of staff had received training in challenging behaviour and dementia. There had been no training in mental health awareness. Staff were not adequately supported with training to meet the needs of people living in the home.

These concerns meant that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that training from external trainers had been booked for infection control, moving and handling, health and safety and mental capacity and DoLS.

Staff told us that training had begun to improve and was now less reliant upon dvd's. One staff member told us, "You can't ask a dvd any questions." They told us that they had received first aid, fire and diabetes awareness training recently. They said, "I've learnt something from all of it." Staff also advised us that they received regular supervisions.

Most people were satisfied with the food, but one person said, "The vegetables are too soft and mushy." We saw records showing that people were given choices about what to eat. The cook told us that they had received recent training in diabetes. They said that they made desserts that everybody could have, so used sweetener rather than sugar. However, some people may have preferred sugar and some may have benefited from the calories provided by sugar. One person who was living with diabetes had requested a jam sandwich for their tea. We were told that they would use diabetic jam, but when we asked to see this there was none available. The cook told us that they would use a modest amount of jam.

People had access to a range of health professionals and were supported to attend health appointments by staff when necessary. However, due to risks to people's welfare not being correctly determined, health professionals were not always engaged to support people promptly enough. One person had not been referred to health professionals despite several falls. Some of these falls indicted that they were slipping out of chairs. However, no action had been taken in relation to this.

Requires Improvement

Is the service caring?

Our findings

Our previous inspection in August 2016 identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to consult with people in relation to the installation of CCTV within communal areas of the home. Concerns had also been raised in relation to practices in the home that did not support people's privacy or dignity.

This July 2017 inspection found that the provider had made attempts to consult with people in relation to the CCTV. No concerns were raised with us in relation to supporting people's privacy or dignity.

Consequently, we judged that the provider was no longer in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were caring. One person said, "I've no complaints about the staff. They ask before they go in my room." Another person told us that they were, "…very helpful." A relative told us, "[Family member] seems happy there. I can't praise the staff enough." Another relative told us, "Staff do a good job. [Family member] takes a lot of looking after.

We were told that staff had obtained a sun hat for one person who spent a lot of time outside. A staff member told us how they encouraged one person to engage with others by telling them that they would appreciate their help with the activities. This resulted in the person being more likely to join in social occasions.

Some people felt that their independence wasn't always supported and felt that they lacked choices on occasions. One person said they rarely got the opportunity to go shopping. They told us that they wanted to choose their own toiletries. Another person told us that they wanted to do some cooking but were told that this wasn't allowed. However, another person said that staff encouraged them to do things for themselves, but would prompt and assist them when necessary. We saw that some people carried out tasks such as laying the table and helping out in the garden. This helped promote their self-worth.

We saw that during lunch jugs of different flavoured cold drinks were available on one table. However, staff moved between the tables with one jug and often did not make clear that an alternative was available to the flavour they were offering.

Some people told us that they felt involved in determining what care they received from staff. One person told us, "I'm able to speak with staff about my care." However, other people felt differently. One person said, "I don't feel that I'm involved. I'd like to discuss ways to help make me more independent, but it doesn't happen." Relatives told us that they were contacted as necessary. One told us, "I'd like to be invited to meetings occasionally as I'd like to know what goes on more generally. But I'm happy they keep in touch with me in relation to [family member]."

Meetings for people living in the home were held every few months. We saw that people's views were sought

on a range of issues including food and how people wanted to spend their time. People felt comfortable to make their views known.

Most people were supported to dress in a way that they wished. For example, we saw that some men wore shirts and ties whilst others dressed more casually. However, one person was dressed in trousers that were several sizes too big for them. The waistband was high on their chest and their trousers had to be held up with braces otherwise they would fall down. A staff member told us, "We need to get [person] some trousers that fit, the ones he has no longer fit him." This person's dignity was not being supported.

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection in August 2016 identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's personal preferences, for example around meals and how to spend their time, were not always taken into account.

This July 2017 inspection found that there had been some improvement in these areas, but we identified other concerns in relation to this regulation.

People's care plans did not always provide clear guidance for staff to ensure they supported people appropriately. One person had experienced a choking episode and staff had dislodged the obstruction. Staff were concerned about the person's swallowing reflex and had been in contact with the person's GP who had made a referral to the Speech and Language Therapist (SALT) service. This appointment was awaited.

However, there was no record detailing definitive actions to be taken pending the SALT assessment. The person's care plan stated that they had 'minor problems chewing and swallowing' and that 'they may require their food to be cut up' The person had choked on a small piece of food. There was no information to indicate what type of food texture the person required pending the SALT assessment or whether a staff presence was required when the person was eating.

Staff were monitoring blood glucose levels for two people for whom they were administering insulin. However, there were no details to guide staff what would be considered an acceptable range for blood glucose levels for each person. One person's blood glucose chart said a reading needed to be taken twice weekly. However, the deputy manager told us that they had been informed by a nurse that as the person's blood glucose readings were stable, this was not necessary. However, there was no guidance for staff to show how often they did need to test the person's blood glucose levels.

The service utilised a computerised care records system. The service was over reliant upon the content generated by the system and had not always personalised it sufficiently in relation to people's specific needs. There were numerous references for staff to 'consider' courses of action to support people with their health or to 'consider' possible risks to people's wellbeing. These were generic prompts on the computer system that had not been amended to reflect what care and support people actually needed or received or what risks they were actually exposed to.

Consequently, the provider was still in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, their relatives and staff told us that opportunities for people go out of the home were few. One person said, "A lot of us would like to go out more. Another said, "I don't do much activities in here, I like to get out and about." One person told us, "I like to read, but I've read all the books here. I'd like to go to the library." Relatives and staff members told us that trips outside of the home had dropped off in recent years.

Where arrangements had been made to take people out, they were not always adhered to. One person's care records stated that they had agreed to a half hour accompanied visit to the pub each week. The person told us they needed staff to accompany them because they used a wheelchair and that they went to the pub approximately once a month. A relative told us that people had been looking forward to a trip out to a model railway. However, transport to and from the stations at either end had not been available so the trip was cancelled. Where access to the community was a condition of some people's DoLS authorisations, the provider could not demonstrate that people were given regular opportunities to participate in activities outside of the home.

There was some provision for activities in the home. For example, we saw people enjoying a movement to music session on one day of our inspection. We were told that bingo, dominoes and board games were also played. An Elvis impersonator was due to visit shortly after our inspection and eagerly anticipated. People had been told that trips out would be planned and they told us how much they were looking forward to them. We were given a list of events that were planned; however there were few definitive arrangements or dates in place. The provider told us that they were at an early stage with this.

Some people told us that they did not wish to participate with the activities on offer, but wanted people to speak with. We spent time in the lounge and dining room areas. There was not often staff in this area unless they were assisting people. Several people approached us for a chat when we were looking at records in communal areas. These people clearly wanted to engage with others but needed staff support for this

We saw that the service had made improvements and had begun to incorporate people's food preferences in to the menus. For example, people had requested crumpets and salmon and these were now offered periodically.

People we spoke with told us that they would raise any concerns they had with staff and felt assured that their concerns would be acted upon. One person said, "Yes, I'd let them know if I'm not happy about something." Others told us that they had no concerns about the care and support that they received.

Inadequate

Is the service well-led?

Our findings

Our previous inspection in August 2016 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the governance of the service. The August 2016 inspection had found poor systems in place to obtain people's feedback about the service, ineffective audits and inaccurate and incomplete care records. Staff had reported a poor culture in the home and felt that their views about the service were not taken into account by the provider.

This July 2017 inspection found that little improvement had been made. The service used the audits that were built in to the computerised care system which were carried out on a monthly basis. These were up to date. However, they were not always robust.

For example, a 'Care Overview' audit asked whether care plans were updated, whether actions from charts, forms and daily records been taken, whether incident forms had been reviewed and followed up and whether appropriate notifications had been made to external bodies. The answer to these checks had been given as 'yes'. However, we found concerns in all of these areas.

No sampling of specific people's care records had been carried out. We found inaccuracies, inconsistencies and omissions in most care records that we reviewed. These issues had led to concerns for people's wellbeing not being identified, acted upon or followed up promptly.

We had requested the service's falls analysis records. We were provided with a list of falls in the previous six months period and what actions had been taken. There had been no analysis to identify patterns to help the provider determine any areas of high risk within the service, for example the time of day or location when falls might more frequently occur. The list we received was not accurate and falls we had identified from the computerised care system were not included on the list. This was because staff had been recording falls on three different parts of the care system. Inconsistent practices in how the system was being used were exacerbating the concerns with people's care records.

When people were awaiting appointments with health professionals there were no systems in place to keep track of these outstanding appointments so that they could be followed up if necessary. Staff initially could not tell us what action had been taken in relation to concerns about one person's swallowing reflex. They had to scroll through numerous records to locate entries that had been recorded several months ago to show that a referral to the SALT team had been made. This information had not been transferred to the person's nutritional care plan where it would have been evident to staff that professional input was still awaited.

The provider had completed most of the care plans that we reviewed, with staff filling in the daily records. However, the provider was not fully engaged in the day to day side of delivering care to people and may not have been best placed to know whether what was recorded was the care that people needed or received in practice.

An infection control audit carried out in June 2017 asked whether all staff had received training in infection control and the answer shown was 'yes'. However, only 46% of staff needing this training had received it.

There was an over-reliance on the computerised care system and its auditing tools. This way the system was being used did not provide assurance that accident and incident forms were fully completed or that care plans were clear about what support people needed. This required a level of scrutiny, judgement and insight about people's needs and the day to day running of the service that was not evident during this inspection.

The manager in the home at the time of this inspection had been in post for about eight weeks. They told us that they had commenced the care management qualification, but needed support from the provider in the meantime and whilst they familiarised themselves with the service. In total, the service had had three managers in the last 12 months. Robust auditing and management systems had not been put in place since the last inspection. This had meant that each new manager had needed to start from scratch and improvements that may have commenced had repeatedly stalled. The provider had failed to drive and sustain improvements following the August 2016 inspection.

The provider was not clear about the level of staffing the home required. On both days of our inspection we saw that up to three care staff were taking their breaks at the same time, leaving little support available for people living in the home. Staffing levels and deployment needed addressing by the service management.

There was a lack of understanding about incidents that needed to be referred to the local authority's safeguarding team or when notifications needed to be made to CQC. Systems were not in place to ensure that this was routinely done.

Whilst some specialised training had been provided to help support staff meeting people's specific needs there had not been suitable training in mental health, challenging behaviour or dementia.
Mental capacity and DoLS were complicated areas and required a greater understanding than had been demonstrated during this inspection in order to ensure that the service operated in accordance with the Mental Capacity Act 2005.
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As a result of the above concerns the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recently arranged for a registered manager from another home to carry out a mock inspection and had just received the report from this, but had not had time to implement any improvements from this.

Feedback had been received from people living in the home by way of a survey. This had very recently been completed and was yet to be analysed and a resulting action plan developed.

Staff meetings were being held monthly. However, the handwritten notes from these meetings were not informative and contained no context to notes such as 'feedback re new recruit', 'care docs' and 'mock inspection'. We could not tell whether staff had been able to input suggestions or who had attended the staff meetings or what actions had been agreed as a result.

Staff we spoke with told us that there had been some improvement in the culture of the service. One told us that the provider was, "..well intentioned, but hasn't got the practical knowledge we need." Another staff member told us that the provider, "…had done their best. But it went downhill again when the last manager left. We are on the up again now though."

People and their relatives were generally positive about the management of the home. One person said, "yes, they are alright here." A relative told us, "The manager genuinely cares about people's wellbeing, it's all to the good." Another said, "The manager is in the office a lot, but they seem okay."

Our previous inspection in August 2016 identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because we had not been notified of incidents that can affect people's wellbeing.

This July 2017 inspection found that no progress had been made in this area. During this inspection we identified six safeguarding incidents needed reporting to CQC. Despite this service caring for people with mental health needs who may exhibit challenging behaviour we had not received a safeguarding notification from the service in over two and half years.

Consequently, the provider remained in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of notifiable incidents that had occurred in the home. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to assess and plan care that met people's needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care was provided in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure safe care and treatment for people because risks to people's welfare were not always identified or acted upon. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment because the provider had not ensured that systems were in place to notify safeguarding concerns to the local authority's safeguarding team. Regulation 13 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staffing levels and deployment of staff were sufficient to meet people's needs. Staff had not received suitable training. Regulation 18 (1) (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)

The enforcement action we took:

We issued a warning notice in relation to this regulation.