Belle Vue Healthcare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Bellevue Healthcare Limited on 19 December 2016. This was an unannounced inspection which meant staff and registered provider did not know we would be visiting.

Bellevue Healthcare Limited is registered to provide care and support to 102 people. There were three units at the service which provided care and support to people living with a dementia, people who required nursing care and young adults living with a physical disability.

A new manager came into post in September 2016 and became the registered manager in November 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspections completed on 21 March, 5 and 18 April 2016 we judged the home to be rated as inadequate and found multiple breaches of our regulations. The service has also been under a serious concerns protocol with the local authority since March 2016.

In April 2016 we noted that no registered manager had been in place since November 2014. Not having a registered manager is a breach of the registered provider's conditions of registration. In June 2016 we issued a fixed penalty notice for this matter and the registered provider paid the £4000 fine in order to deal with this breach.

We carried out a further inspection on 12 May 2016 because of growing concerns about people's safety. We found that although the level of risk had not increased concerns remained around ensuring people received safe care and treatment. People's level of risk from staff failing to administer medication in line with their prescriptions remained unchanged. When people lost weight, we found staff were still failing to ensure referrals to dieticians were consistently made.

Due to concerns still being identified we completed an inspection on 5 and 16 September 2016. We also wanted to make sure the registered provider was taking action to address the concerns which we had identified during the last two inspections completed in April 2016 and May 2016.

We identified that four people were grossly underweight and all had Body Mass Indicators (BMI) of below 18. This showed that people were at risk of being malnourished and developing a compromised immune function; respiratory disease; digestive diseases; cancer and osteoporosis. One person had a BMI of 12, which placed them at very high risk of developing life threatening health conditions. Despite staff referring people to dieticians in July 2016 they had referred individuals when they continued to lose weight and their BMI were extremely low.

Following our visit on the 5 September 2016 we wrote to the registered provider to make them aware of our serious concerns about people's welfare and asked them to take immediate action to ensure people's health was not compromised. On 16 September we visited to check that the action the registered provider had said would be taken had occurred. We found that they had compiled a list of people's current weight and people who had wounds. They had contacted GPs and dieticians for all people who were found to have compromised weights and those with wounds.

We also found that one of the registered provider's directors, who is a retired GP and without a license to practice had been completing and signing 'Do not attempt cardio-pulmonary resuscitation' (DNACPR), as senior consultant. This is a breach of the Medical Act 1983. We issued a Notice of Decision under our urgent powers requiring that the provider review the fitness of this director and investigate the completion of the DNACPRs and the role of the clinical lead. Subsequently the director stepped down from the company.

On 13 October and 11 November 2016 we completed a further inspection because the local authority reported they were observing significant improvements in the operation of the home.

We did initially find evidence that action had been taken to refer people to health professionals for nutrition, dehydration and pressures sores although care plans had not been developed/updated. However, in November 2016 we found that these minimal improvements had not been sustained. The registered provider continued to fail to ensure people were receiving safe and effective care and treatment on multiple levels. We found steps had not been taken to ensure service users received adequate fluids, were not unintentionally losing weight, identified wounds were managed appropriately and that service users received safe care and treatment.

We found at the inspection in November 2016 that one person who received food and fluid via Percutaneous endoscopic gastrostomy (PEG) had not had their records relating to this updated. A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate, for example, because of dysphagia or sedation.

We issued a Notice of Decision under our urgent powers requiring that no one was admitted to the home without first discussing this with us. Action was also taken to manage risks for two people, complete capacity assessments for these two people and assess the competency of the staff deployed at the home.

At this inspection we found that the person's care plan had been reviewed and updated but this did not reflect the times specified in the dietician's letter.

Another person's PEG regime information did not match that set out by the dietician and there was conflicting information in the care records about the volume of the additional fluids.

For two people their PEG regimes were not always recorded as given. Also one person needed their PEG balloon to be checked each Sunday but the records showed this was not occurring as required.

We asked the registered provider and registered manager to take action to ensure people's PEG regimes were followed and reported these matters to the local safeguarding team.

We found that a new system for medication administration had been introduced, which was computerised. It alerted the registered manager and pharmacists to stock need and deviation from prescribing guidelines. However, it only became operational on 3 December 2016 so reports and alerts had yet to be produced. The

new system had led, potentially short-term, to an increase in the time taken to administer medicines. We established that stock balances were correct.

We found that one person's insulin medication was not administered in line with the prescription.

We asked the registered provider and registered manager to investigate the discrepancies around the insulin administration and reported this matter to the local safeguarding team. The registered manager contacted the pharmacist to ask them to check the electronic administration sheet to see that the right amount of medication had been given. They also liaised with the person's diabetic nurse to ensure they were administering medication correctly and obtain written evidence of the latest prescription and instructions around when to administer the insulin.

We also found on 19 December 2016 the nurse recorded that they had given a morning insulin dose of 10 units when the person's blood glucose level was 5.9. When we questioned this the nurse crossed out the entry of 10 units and wrote six saying it was a mistake.

Again we found that actions identified in audits and incident reviews were not completed such as one person pulled a metal curtain pole down on themselves in November 2016. The incident form records to prevent further injury the poles were to be removed and replaced with light weight ones. The action was to be completed by 27 November 2016. However, we saw that one pole remained in situ and the other window had no curtains or pole in place.

We found that the senior managers were introducing new systems for overseeing the home such as provider audits but these, and the other systems were not picking up the issues we found. Actions from care plan audits completed in October 2016 were still not completed.

We could see that staff had been participating in training, however not all staff were up to date with their mandatory training. We reviewed the training records for all nurses and care staff and found that no area of training was up to date for all staff. This meant that we could not be sure if staff were competent to provide care and support to people. We obtained feedback from the people involved in completing competency checks on the staff. This showed that although staff had received up to date training they were not putting this training into practice.

Staff still did not ensure they gave sufficient fluids or demonstrably took action when people had reduced fluid intake or passed more fluids than they consumed. They still took no action when people refused to have their weight taken or lost significant weight. The registered manager told us when staff had contacted the GP about people not taking sufficient fluids for three days they had been shouted at and told not to call them. No records were available to show when this occurred or what GP had behaved in this manner.

We found multiple inaccuracies in eight sets of care records we reviewed. Again care plans were contradictory. Although improvements had been made to the MCA information for the two people mentioned in the Notice of Decision this had not been extended to others. Records for three people indicated they all had memory impairment and were forgetful but their care records stated they had capacity to make decisions. No information was provided to detail how they had reached this conclusion.

The manager of the young adults unit had identified two people at risk of malnutrition and trialled smoothies with them to reduce the risk of weight loss. This information had not been updated in the care records, however we spoke to one of the people and they told us they had enjoyed them. This manager told us they had reacted quickly when one person was given rice to eat by staff despite a risk of choking. The

manager contacted the dietician and SALT team for advice about dietary intake for this person.

The registered provider had introduced a new accident and incident reporting procedure. We found that not all staff were aware of this new procedure, despite available guidance. We found that accidents and incidents on the dementia unit had been regularly reported by staff; however we were concerned that no accidents or incidents had been reported on the young adult's unit and elderly care unit.

Staff could not find anyone's records for food and fluid for the previous week and we were informed that they had been archived. We looked for the most recent archive material and found the information was not there and the records were all jumbled. We pointed out at the last inspection that the record keeping was chaotic and documents were haphazardly put in the broken archive folders. This remained the same and recent letters from healthcare professionals, notes, old care plans and fluid balances charts were jumbled together. The registered manager told us they had been unable to complete a complaint investigation for a person who lived at the home last year because all the records were not available.

We found the provider was continuing to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified during inspection on 21 March, 5 and 18 April 2016. These breaches related to safe care and treatment, dignity, consent, person-centred care, nutrition, safeguarding, staffing and governance. The overall rating for the service was 'Inadequate' and this will remain. The service will remain in 'Special measures'. Services in special measures will be kept under review. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

We have judged the risks posed to be major and are taking action in line with our enforcement policy.

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.

Staff failed to recognise when poor practices should be reported to local authority safeguarding teams.

Risk assessments were not always in place where needed.

Care plans did not always accurately reflect people's health needs and risks.

People's health, safety and wellbeing continued to be at risk, especially in relation to people who needed insulin, people who were PEG fed, dehydration and malnutrition.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place at the service were failing to appropriately recognise and respond to people who were at risk of choking, malnutrition and dehydration.

Despite new audits being put in place care plans remained inaccurate and did not reflect people's individual needs.

Quality assurance processes had not highlighted the concerns we found during this inspection.

Bellevue Healthcare Limited

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.

Three adult social care inspectors completed the inspection on 19 December 2016 and commenced the visit at 6am.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We reviewed feedback from the local authority commissioning team for the service, from the serious concerns protocol forum (which we have regularly attended) and from the clinical commissioning group (CCG).

During the inspection we spoke with five people who used the service. We also spoke with two of the directors from the registered provider's company, registered manager, two employees of a consultancy service who have been employed by the registered provider to assist them make improvements at the home, three nurses and five care staff.

We spent time with people in the communal areas and observed how staff interacted and supported people. We looked at 12 care records, medicine administration records, weight monitoring records and pressure care records. We also reviewed staff rotas, training records and quality assurance records.

We looked around the service and went into some people's bedrooms and bathrooms (with their permission) and spent time in communal areas.

Inadequate

Is the service safe?

Our findings

We found at the inspection in November 2016 that one person's who received food and fluid via Percutaneous endoscopic gastrostomy (PEG) was not being given adequate fluids. A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate, for example, because of dysphagia or sedation. We saw a dietician's letter dated 16 September 2016 stated they must receive 700mls of fluids each day in addition to food and flushes but the care records had not been updated. We discussed this with the nurse who told us they were unaware of the change to the regime. The nurse informed us that the person required 500mls of fluid per day. However, inspectors noted that they had not even been receiving the 500ml of fluids per day. We reported this matter to the local safeguarding team.

At this inspection we found that the person's care plan had been reviewed and updated but this did not follow the times specified in the dietician's letter. The plan recorded that the individual was to receive 250mls of Fortisip at 2pm and 125mls at 8pm. But this should have been the other way around in the dietician's letter. The staff could not tell us why this had changed and there was no evidence in the care records to show new instructions had been issued. Although the person's PEG regime now recorded they were to have 700mls of additional fluid the records showed they were only receiving 500 to 550mls of fluid.

Another person PEG regime information did not match that set out by the dietician and there was conflicting information in the care records about the volume of the additional fluids. The dietician letter recorded they were to get 250ml flush but the feed regime said 200ml. We saw that at the last feed they were supposed to get 110 ml pre and post, however staff were only giving 60mls. There was nothing recorded to say why staff had made these decisions.

For two people their PEG regimes was not always recorded as given. Also one person needed their PEG balloon to be checked each Sunday but the records showed this was not occurring as required.

We asked the registered provider and registered manager to take action to ensure people's PEG regimes were followed and reported these matters to the local safeguarding team.

This was a continued breach of regulation 14 (Meeting nutritional needs) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We found that a new system for medication administration had been introduced, which was computerised. It alerted the registered manager and pharmacists to stock need and deviation from prescribing guidelines. However, it only became operational on 3 December 2016 so reports and alerts had yet to be produced. It had led, potentially short-term, for increase in the time taken to administer medicines. But we established that stock balances were correct.

We found that one person's insulin medication was not administered in line with the prescription The prescription stated six units of insulin to be administered if her blood glucose reading was below 9mmol and

a further two units to be given if above 9mmol and another two if over 15mmol. The diabetes management information dated 18 December 2016 stated seven units to be given twice a day. The blood monitoring sheet showed that if her blood glucose was below 5mmol staff were not always administering the insulin but none of the staff could explain who had agreed this change.

The nurse said "I was not the nurse on duty when this was decided, but I just know, I don't know where it is recorded." We saw that the time of administering the insulin was 8:30 on the paper copy but 9:14am on the electronic copy; we questioned the discrepancy with the nurse who said, "My watch must be different." We asked the registered manager to investigate the discrepancies around the insulin administration.

We asked the registered provider and registered manager to investigate the discrepancies around the insulin administration and reported this matter to the local safeguarding team. The registered manager contacted the pharmacist to ask them check the electronic administration sheet to see that the right amount of medication had been given. They also liaised with the person's diabetic nurse to ensure they were administering medication correctly and obtain written evidence of the latest prescription and instructions around when to administer the insulin.

We also found on 19 December 2016 the nurse recorded that they had given a morning insulin dose of 10 units when the person's blood glucose level was 5.9. When we questioned this the nurse crossed out the entry of 10 units and wrote six saying it was a mistake.

The registered provider had introduced a new accident and incident reporting procedure. We found that not all staff were aware of this new procedure, despite available guidance. We found that accidents and incidents on the dementia unit had been regularly reported by staff; however we were concerned that no accidents or incidents had been reported on the young people's unit and elderly care unit.

In one of the accident and incident records [dated 18 November 2016] looked at, we noted that some actions remained outstanding. Staff had ensured that the person's medicines were reviewed, however the action plan stated that thirty minute observations should be carried out at night and that the two metal curtain poles should be removed and replaced with light weight poles to reduce the risk of injury. A risk assessment for curtain poles also stated that they should be replaced. The care records contained conflicting information about checks of the person. The behaviour care plan stated that 15 minute checks should be completed; however this had been crossed out. A mobility care plan stated that two hour checks should be carried out. We spoke with a team leader and they told us that all staff carry out two hourly checks of every person using the service and that this person should be on thirty minute checks. This meant that staff had failed to carry out the thirty minute checks since 18 November to keep this person safe.

We looked in the person's room and found one metal curtain pole had been removed and not replaced and the second curtain pole remained in situ. We asked staff whether it was appropriate for the person not to have curtains up and holes in the wall where the pole had been removed. We asked why the second metal pole had not been removed since it posed a risk to the person. Staff could not answer our questions.

The manager of the young adults unit had identified two people at risk of malnutrition and trialled smoothies with them to reduce the risk of weight loss. This information had not been updated in the care records, however we spoke to one of the people and they told us they had enjoyed them. This manager told us they had reacted quickly when one person was given rice to eat by staff despite a risk of choking. The manager contacted the dietician and SALT team for advice about dietary intake for this person.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act

2008 (regulated activities) regulations 2014.

During our comprehensive inspection of the service on 21 March, 5 and 18 April 2016, we identified that care plans were not person-centred and lacked the detail needed to provide care and support to people safely and according to their wishes, needs and preferences. Care plans were not always reviewed within the timescales set by the registered provider. People had the same care plans in place regardless of whether they were needed. Some people did not have the care plans in place which were specific to their individual needs.

In October and November 2016 we found that the care plans remained difficult to follow and again some care plans were inaccurate. We found that some people's care records failed to identify the significant risks being posed. A care plan audit for one person highlighted that a risk of choking and complications to nutrition resulting from their health condition needed to be updated in the person's care plan. Recommendations following contact with the SALT team and information about how the person could communicate with people also needed to be included into the person's care plans. However, these had not been completed.

At this inspection we again found the care plans contained contradictory information. Although care plan audits had identified gaps in the plans and inaccuracies the staff had not corrected the plans.

A care plan for one person informed that they could be verbally and physically abusive towards staff whenever care and support was delivered. We were concerned that staff had not recorded any incidents of abuse towards them in the persons care records and that accident and incident records had not been completed. We spoke with the manager of the young people's unit and they told us this person displayed behaviours which could challenge, but not at the level identified in the care plans. They told us the care plans were not accurate and did not reflect actual behaviours shown. Since starting, the new manager of this unit told us they had identified an increase in the person's behaviour when they were positioned on to the right hand side of the body. The manager told us the person had experienced a stroke and felt the behaviours were due to discomfort. This information had not been updated in the person's care records. We could see that the manager had informed staff about this and had taken action to make appointments with the person's dentist and Occupational Therapist. We questioned why staff had failed to make the same observations and notice that support from health professionals was needed. The registered manager could not explain why the staff failed to recognise these issues.

We saw that staff were recording fluid balances for people and noting their intake and output. But when people drank below the recommended amount or their output of liquid was greater than what they had consumed that day there was no evidence to show action was taken to contact healthcare professionals. For instance one person consumed 2500ml of fluid but passed 3150mls. Health-line guidance states urine output is considered excessive if more than 2500mls is passed and could be indicative of underlying conditions such as bladder infection, diabetes, kidney failure, kidney stones and certain forms of cancer. Also losing more fluids than taken can cause dehydration.

Other people were recorded as consuming between 300mls and 950mls but no record was maintained around any action the staff had taken to encourage the individuals to drink or contact with the GP and other healthcare professionals. The registered manager informed us that when staff had contacted the GP about people not drinking for several days they had shouted at them and told them not to ring about this anymore. There were no records to confirm this had occurred. When we spoke with staff they told us that nothing could be done if the person refused to drink .We discussed the use of subcutaneous fluids to assist people increase their fluid intake with the registered provider and registered manager. Both felt it was not in

the best interests of people to use this technique to improve fluid intake and neither could tell us how they would reduce the risks of dehydration.

None of the care records identified that even mild dehydration adversely affects mental performance and increases feelings of tiredness. Mental functions affected include memory, attention, concentration and reaction time. Common complications associated with dehydration also include low blood pressure, weakness, dizziness and increased risk of falls. Poorly hydrated individuals are more likely to develop pressure sores and skin conditions. Water helps to keep the urinary tract and kidneys healthy. When fluid intake is reduced the risk of urinary tract infections increases. Inadequate hydration is one of the main causes of acute kidney injury. Staff we spoke with did not outline any of the risks associated with dehydration.

At the November 2016 inspection we found that people's fluid balance and dietary intake records had been stored in a jumbled manner in broken lever arch folders at the bottom of filing cabinets. We found at this inspection we found that staff continued to haphazardly store documents in broken lever arch folders. We found recent letters from healthcare professionals, old care plans, fluid balance charts, documents about the action taken to audit the whole home and body maps jumble together in people's archive boxes.

Staff on the older person's nursing unit could not find the previous week fluid balance charts and monitoring records. This meant they could not look at the lead up to one person being admitted to hospital after becoming unresponsive. Also when this person returned to the home the staff did not obtain the discharge notes from the hospital so were unaware of what had caused them to be unresponsive. We pointed this out to the registered manager who ensured the information was obtained and staff reviewed this to look at what changes in care were needed.

This is a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The registered provider had introduced a new electronic system on the 3 December to manage medicines. The system was introduced to improve safety and compliance in administration of medicines. Due to the system only just been introduced it was too early to run off full reports. We could see reports on late medicines and the reason why, report on who was prescribed antibiotics and which staff had completed a medicine round and the time it took. The system alerted the registered manager if a medicine was missed, the system would also not allow a medicine to be administered if it was too early, for example not leaving four hours between each Paracetomol administration.

We observed a morning medicine round; the staff member knew the electronic system well and could easily explain the functions. We saw the staff member checked if the person wanted their medicines before administering. If they refused at that time or were still asleep the staff member said they would try again later, the system would stay red until the medicine had been administered or until a reason for refusal had been documented.

The system did a full count on medicine stocks; we checked three boxed medicines and found they were correct. We were told that the electronic system monitored stock and sent an alert if stock was becoming low.

We found medicines were stored securely and daily temperature checks were done of the room medicines were stored in and the refrigerator where medicines were stored.

Staff knew the required procedures for managing controlled drugs. Controlled drugs are drugs that are liable to misuse. We saw that controlled drugs were appropriately stored and signed for when they were administered.

Inadequate

Is the service well-led?

Our findings

At the last comprehensive inspection completed on 21 March, 5 and 18 April 2016 we judged the home to be rated as inadequate and found multiple breaches of our regulations. The service had been placed under a serious concerns protocol with the local authority since March 2016. The professionals involved in the serious concerns protocol had significant concerns about the registered provider's ability to provide safe care and support to people. An embargo was put in place in March 2016 which meant that nobody new could move into the service.

In October 2016 the local commissioners told us they believed the service had significantly improved and were looking to start to admit people to the home. We inspected and found that improvements had not been made and people remained at significant risk. In November 2016 we issued a Notice of Decision (NoD) under our urgent powers requiring that no one was admitted to the home without first discussing this with us. Action was also to be taken to manage risks for two people, complete capacity assessments for these two people and to assess the competency of the staff deployed at the home.

Not having a registered manager is a breach of the registered provider's conditions of registration. Following the inspection completed in April 2016 we issued a fixed penalty notice for this matter and the registered provider paid the £4000 fine in order to deal with this breach.

A registered manager had been in place since November 2016. Staff told us they had confidence in the registered manager and felt they were making improvements at the service. One staff member told us, "Things are improving. [Registered manager] is very approachable."

The registered manager was open and honest during inspection. They told us change had been difficult to achieve and a change to the culture at the service was needed as well as the staff team working together. We could see they were putting systems in place but these did not always achieve the outcome needed because at times staff failed to report concerns or failed to take the action needed. Staff responsible for carrying out quality assurance checks and completing care records failed to take the action needed when concerns were evident from these records. This meant the registered manager had not always been able to take action because they had not been made aware.

During previous inspections we had highlighted the continued gaps in care records. The registered provider told us that they would take action to complete an audit of all care plans. During the last inspection, we highlighted that although some care plan audits had been completed, many remained outstanding. Where care plan audits had been completed and actions identified, they remained unaddressed. At this inspection we noted that these action plans still remained unaddressed; this meant that care records had not been updated to reflect people's actual needs and risks.

External consultants working with the registered provider had identified common themes in their care plan audits which were scheduled to be completed by 28 December 2016. These included gaps in risk assessments and care records. Where audits had been carried out by these consultants, action plans had

been created and deadlines put in place for staff to make the changes needed to the care records. We found that these deadlines had passed and actions had still not been addressed. Significant numbers of care plan audits had still not been completed; this meant that care plans had not been updated to contain the most accurate and up to date information.

We could see that staff had been participating in training, however not all staff were up to date with their mandatory training. We reviewed the training records for all nurses and care staff and found that no area of training was up to date for all staff. This meant that we could not be sure if staff were competent to provide care and support to people. We obtained feedback from the people involved in the competency reviews. From this we established that staff had received up to date training, however they were not putting this training into practice.

The registered provider and registered manager told us that they were currently looking at their training provision to look at how they could match training to particular learning styles. They told us that they would also introduce regular staff competency checks.

The service had continued to carry out internal audits. Since the last inspection, catering, infection prevention and control, malnutrition universal screening tool (MUST) and health and safety audits had been carried out. We noted that action plans were in place and actions had been signed to say they had been addressed. Weekly audits for pressure area care had also been carried out as shared with the local authority under SCP arrangements. During inspection, we noted that staff had continued to fail to record changes when people lost weight. We also found that staff completed the MUST on a monthly basis when people were required to be weighed weekly because of the risks to malnutrition. This had not been identified in the MUST audit.

Although accidents and incidents had been reported on the dementia unit, we found that staff had failed to implement the actions identified to reduce the risk of harm and the risk of reoccurrence. We found that the registered provider and registered manager had failed to ensure that actions to reduce the risk of harm from accidents and incidents had been followed up.

The registered provider and registered manager had an action plan in place for the service to work towards making the improvements needed. This action plan stated that all safeguarding incidents and accidents and incidents would be analysed each month to identify any patterns and trends, however no records were available for inspection. We could see that accident and incident records were checked for accuracy during health and safety audits, but not patterns and trends.

Following the last inspection, we asked the registered provider to take immediate action to carry out competency reviews of all staff employed to provide care and support to people. We could see that where further support was needed for nurses, training had been put in place. We noted that some competency reviews were outstanding because some nurses were on holiday and one nurse had refused to complete their competency review. Not all staff were up to date with the nursing and midwifery code of conduct and the action they needed to take to ensure all care given was recorded.

Competency reviews of care staff were on-going; however the registered provider had been made aware of some initial areas for improvement. These included gaps in knowledge and a lack of confidence.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

There was some evidence that Best Interest meetings had been held but this only extended to the two people identified in the NoD. A letter from one person's GP stated it was essential that the person had two of their medications. A best interest meeting took place on 6 December 2016 and the minutes indicated they were to have two of their medicines covertly and the advocate had to find out how to implement this proposal. No further information was available to show this action had been taken and no care plans for convert administration were in place. The nurse told us they still offer the person medication and accept that they may refuse them. Also staff were to look at how they could encourage the person to manage oedema in their feet; and their refusal to take food and fluid. There was no evidence in the care records to show that any of these actions had been taken.

We also saw that the person had been assessed in 2014 as requiring a soft diet and thickened fluid because they had an impaired gag reflex and were at high risk of choking but refused to follow the Speech and Language Therapist (SALT) team advice so received a normal diet. In November 2016 the capacity assessment for this person recorded that the individual was aware that eating a normal diet could be fatal either because of choking or aspirational pneumonia. In August 2016 the SALT team recommended the staff revisit the person's capacity to make this decision due to the continued high level risk being posed by the refusal to eat a soft diet and take thickened fluids. However, no one from the service had completed a capacity assessment for this specific decision. The capacity assessment the registered provider sent us stated the person lacked capacity to consent to care and treatment, make the decisions not to have medication or address their personal hygiene needs. However, we found that their updated nutrition plan state the person had fluctuating capacity but agreed to adhere to the SALT team recommendations.

This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

A director for the service met with us on the day of inspection and told us they were becoming more involved in supporting the service to make improvements. This support would be looking at business challenges, staffing and risk. Staff spoke positively about the registered manager. One staff member told us, "[Registered manager] is brilliant. She cares."

The registered provider had employed a new manager to the young adults unit and we saw evidence to show that they had been allocated time to update all care plans and ensure all supplementary records such as food and fluid balance records were accurate and up to date. The registered provider had put timeframes in place by which time they expected action to be taken.