Bupa Care Homes (CFHCare) Limited

Saltshouse Haven Care Home

Inspection report

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09 September 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Saltshouse Haven is registered to provide care for 150 people, some of whom may have nursing needs or who may be living with dementia. The service is located on the outskirts of Hull and has good public transport access. The service is divided into five separate lodges, Sutton (closed at present), Coniston, for people with nursing care needs, and Bilton, Preston and Meaux for people with residential care needs. Each lodge has a separate entrance, their own communal rooms, bedrooms and an external garden. Administration is carried out from the main building and laundry and catering are delivered from another building within the site. Each lodge has a 'unit manager'.

The service had a registered manager in post as required by a condition of their registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Saltshouse Haven had a full comprehensive inspection in September 2015 and concerns were found regarding how people received person-centred care, dignity and respect, safe care and treatment, managing complaints, good governance, staffing and obtaining consent. We issued warning notices for staffing and consent and requirement notices for the other concerns. The service was rated as Inadequate and placed into special measures, which meant we were to follow up with another inspection within six months. A full comprehensive inspection to follow up the requirement notices and warning notices was completed in February 2016 and we found significant improvements had been made. The service was removed from special measures and rated as Requires Improvement. Although compliant with the requirement notices and warning notices at the February 2016 inspection, we wanted to make sure the improvements were sustained and we planned to return and inspect the service again within 12 months.

Findings specific to Coniston lodge:
Due to concerns raised by health professionals we inspected Coniston lodge 11 and 26 August 2016. As a result of findings, we decided to take urgent action and liaised with the local authority and Hull Clinical Commissioning Group to ensure the people who lived on Coniston lodge were found alternative placements at other services for their nursing care. The registered provider's representative was informed of the decision. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. Due to the level of risk and concerns found during the inspection, the registered provider agreed to a voluntary suspension on further admissions to Saltshouse Haven.

The concerns found on Coniston lodge resulted in us finding the registered provider in breach of nine regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches included, management of the service, providing person-centred care, the need for consent, safe care and treatment, safeguarding people from abuse and improper treatment, meeting nutritional and hydration

needs, good governance and staffing.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'; this is the second time the service has been in 'special measures' in a 12 month period and the registered provider must take action to improve and sustain the improvements. 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 registered 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.

We found inadequate staffing levels had impacted on the quality of care people received on Coniston lodge. People who used the service had sustained injuries due to a number of poor moving and handing incidents, staff had to be prompted to take action regarding one person's health care needs, some people's nutritional needs were not met and seating arrangements when people ate their meals was not always appropriate or safe.

There was a lack of robust risk management, staff had not always following guidance from health professionals and there was the use of improper physical interventions for one person.

Some people had not received their medicines as prescribed due to stock control issues, errors in administration and non-application of creams. Some people had poor hand and nail care and personal hygiene.

We found general concerns in documentation such as care planning and recording, advice from health professionals not transferred to care plans, risk assessments identified issues but lacked some control measures and care plans were not always updated following incidents. There was a lack of follow-through in recording of some issues so it was difficult to see if the care had been provided and the issue addressed. There were gaps in some people's monitoring charts and wound care records, and re-dressing times were not always followed.

There were concerns with the management of infection prevention and control as some areas and equipment required cleaning.

We found specific staff lacked understanding about the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, obtaining consent and carrying out care and support in people's best interests. Documentation that showed best interest decision-making had not been completed appropriately.

Findings for the service as a whole:
There was a policy and procedure to guide staff in how to manage complaints and a record was held of investigations and outcomes. Improvement was required regarding a more customer focus approach and accuracy of the complaint letters sent out to people who had raised concerns.

There was insufficient induction, supervision and support to staff in lower management positions. There were shortfalls in how the service was managed overall and how care staff were overseen and supported when carrying out their roles. Some care staff had received formal supervision but others had not received any for some months. Staff had received a range of training but we were concerned some areas had not been fully understood.

We found audits had taken place regarding Saltshouse Haven as a whole, which highlighted specific issues, but there lacked analysis to ensure lessons were learned and incidents did not reoccur.

Findings specific to Bilton, Preston and Meaux lodges:
We decided to complete further inspection visits to Saltshouse Haven on 8 and 9 September 2016 to assess the care people received on the other three remaining lodges, Bilton, Preston and Meaux. On the days of the inspection there were 17 people who used the service on Bilton lodge, 18 on Preston lodge and 25 on Meaux lodge. During these two inspection days, the service was overseen by a regional director for the registered provider, BUPA. There were also other senior managers on site supporting staff with reviewing care plans and risk assessments.

We found there were sufficient staff on duty on each of the residential lodges as some members of staff had moved across to them when people moved from Coniston lodge to alternative placements. However, staff told us prior to the changes, there were days when there was insufficient staff on duty and this had impacted on the care and monitoring they were able to provide. The regional director told us they would complete a staffing review to ensure sufficient staff were on duty in line with people's care needs.

We found employment checks were carried out prior to new staff starting work in the service. The recruitment process helped to ensure only suitable staff worked with vulnerable people. In one staff file we found gaps in their employment history had not been explored and documented.

There were policies and procedures to guide staff in how to safeguard people from the risk of harm and abuse. Staff had received safeguarding training and were able to describe the different types of abuse and how to report any issues of concern.

We saw people who used the service had assessments and care plans. The assessments did not always comment on the impact on people of their health needs and disabilities. Care plans did not always detail guidance for staff regarding the support people required to meet their assessed needs.

The care files included information about visits from professionals which helped to ensure people's health and social care needs were met. However, in one instance in particular, we found the information from professionals had not been communicated to all staff. This placed the person at risk of not having the correct texture of meals to aid their swallowing difficulty.

Risk assessments had been completed but, as with Coniston lodge, the control measures were not always indicated and in two instances the risks had not been addressed properly.

We saw the lodges were clean but some items of furniture, for example over-bed tables and some under sink

boards had exposed woodchip which made them difficult to clean and the edges were rough. We also found some bed rail protectors were stained and in places dirty; these were stored during the day on the floor under the bed, which harboured dust.

We checked how medicines were managed on each of these three lodges and found people had received them as prescribed. The medicines were obtained, administered to people, recorded, stored and disposed of appropriately.

We observed positive interactions between staff and people who used the service. We also received positive comments from people we spoke with and their relatives. Staff supported people to maintain their privacy and dignity.

We saw meals were nicely presented and menus provided choice and alternatives. Staff supported people to eat their meals in an appropriate way and at a suitable pace for them.

There were activities for people to participate in and occasional trips to local venues.

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.

Although staff had received safeguarding training and procedures were in place to guide them, some people on Coniston lodge had been exposed to potential abuse and experienced harm and injuries due to improper and unsanctioned physical interventions and poor moving and handling techniques.

Risks to people had not been managed in an appropriate way.

There were insufficient staff available on Coniston lodge which had led to some people not receiving the care they needed. There were sufficient staff on the other three lodges on the day of inspection but we were told a staffing review was to take place to ensure adequate levels were in place every day.

On Coniston lodge people had not always received their medicines as prescribed, which could potentially affect their health and welfare. Medicines management was judged as safe on the other three lodges on the day of inspection.

There was a failure to ensure good infection prevention and control. Systems for checking the environment, replacing some equipment and appropriate storage of items was required to ensure improvements were made.

Is the service effective?

Inadequate

The service was not effective.

The registered provider had not acted within the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards in place to protect people and plan for their care when they lacked capacity to make their own decisions.

People had access to health care professionals for advice and treatment. However, there were instances when staff had not followed the advice and treatment plans.

Not everyone's nutritional and hydration needs had been met in

an appropriate and safe way. The menus provided people with choice and alternatives and the meals looked well-prepared.

Staff had received training in a range of subjects, however, there were instances when staff demonstrated they were not fully competent to provide care and this had affected their judgement and good practice principles.

Staff received an induction, supervision and on-going support. There were differing views from staff about how effective this was.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed examples of positive interactions and compassionate care provided by staff. However, this was not consistent in Coniston lodge, where there were concerns identified in staff approaches and the delivery of some aspects of care which affected people's dignity, comfort and wellbeing.

We observed people's privacy and dignity was respected on the residential lodges and independence was encouraged as much as possible.

Relatives told us staff provided support and care for them as well as their family members.

Apart from one instance, which was addressed on one of the days of inspection, personal records were stored securely. Staff respected confidentiality when making phone calls or holding discussions about people who used the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had assessments and care plans of their needs, but these lacked important information about how care was to be delivered in a person-centred way.

Staff had not always responded to people's changing needs in a timely way which had impacted on their safety and wellbeing.

Although there was an activity programme to provide stimulation and meaningful occupation for people on the residential lodges, not everyone on Coniston lodge had benefitted from this.

The registered provider had a complaints procedure and people felt able to complain in the belief issues would be addressed. Accurate recording of people's names and a more customer focus in response letters would enhance the complaints process.

Is the service well-led?

Inadequate

The service was not well-led.

There were concerns about the general management and oversight of the service which meant improvements noted at a previous inspection had not been sustained. Morale was described as low at times and there had been a lot of staff changes resulting in inconsistency of care for people.

There was a failure to analyse information gathered during the quality monitoring process which meant lessons were not learned and practice had not changed in order to improve the service.

As a result of concerns, the registered provider had acted to reinstate a 'recovery team' to provide senior management oversight and guidance to the staff team.

Saltshouse Haven Care 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 in response to concerns and was planned to check whether the registered provider was 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 11and 26 August and 8 and 9 September 2016 and was unannounced. On the 11 August 2016, the inspection team consisted of two adult social care inspectors. On the 26 August 2016, the inspection team consisted of two adult social care inspectors and a registered general nurse from Continuing Health Care commissioned by Hull Clinical Commissioning Group. On the 8 September 2016, the inspection team consisted of two adult social care inspectors and a representative from the local authority commissioning team. On the 9 September 2016, the inspection team consisted of two adult social care inspectors.

The registered provider had not yet been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority safeguarding, and contracts and commissioning team about their views of the service. We also spoke with members of the continuing health care team and a health professional who was a safeguarding lead and had raised concerns with us about the service.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We used the Short Observational Framework for Inspection (SOFI) on Bilton, Preston

and Meaux lodges. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who used the service and 17 people who were visiting their relatives. We spoke with a range of staff which included the regional director, the registered manager, a unit manager, a nurse, two senior care workers, 12 care workers and two hostesses (who served meals to people on Coniston lodge). During the inspection, we also spoke with two visiting health professionals and two members of an ambulance crew who were collecting a person for a routine hospital visit.

We looked at 20 care files which belonged to people who used the service to check how their needs were assessed, any risks identified and to see how care was planned and recorded as delivered. We also looked at other important documentation relating to people who used the service. This included medication administration records (MARs) for all people who used the service and some monitoring charts for food, fluid, weights, pressure relief and changing behaviour. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, probationary forms, training records, the staff rota, minutes of meetings with staff, quality assurance audits, surveys, complaints management, compliments received and maintenance of equipment records.

Inadequate

Is the service safe?

Our findings

We saw staff had received training in how to safeguard people from the risk of abuse and harm and there were policies and procedures to guide them in the action to take should they witness abuse. However, we found people who used the service on Coniston lodge had not always received care that was safe, and on some occasions their needs had been neglected and staff had not safeguarded them from the risk of harm and abuse. For example, some people had received injuries, such as skin tears and bruising, from a number of moving and handling incidents. This was despite staff having received training for moving and handling. One person had been assessed as requiring a special chair to prevent falls. They fell from the special chair and sustained a fracture; they were inappropriately hoisted before a full check was completed of possible injuries which had the potential to cause unnecessary pain.

One person's fluid intake had been neglected on specific days; on 25 and 26 August 2016, they had not been provided with sufficient fluids to sustain their health and there was a concern about their urinary output. The registered nurse, who was part of the inspection team, was concerned about the person and they arranged medical intervention. We spoke with the unit manager about our immediate concerns and they ensured the person had regular fluids for the rest of the day and evening until they were assessed at hospital. From 12 noon, when the deficit was first noticed by inspectors, until 7pm when the ambulance arrived, the person had over a 1000mls of fluid with further fluid intake and urine output in A&E. This meant they were not dehydrated and did not need to be admitted. The person was returned home without further treatment. However, we were concerned that this issue may not have been addressed if inspectors had not raised it with staff.

We found staff had used physical interventions each day with one person during personal care tasks and it was recorded they were distressed each time. The physical interventions had not been appropriately sanctioned, via the use of mental capacity legislation, as the least restrictive option regarding the person's care and support. A Deprivation of Liberty Safeguard application had been submitted in January 2016, but had not been followed up as a matter of urgency when physical interventions were used during delivery of care. There was a lack of information in the person's care plan to guide staff in how to support them with personal hygiene. Meetings with professionals had been held but no record of their advice was included in care plans. On occasions, staff reported the person declined care and they would leave them and return later when they consented to care. Staff also recorded the person had declined care but they gave it despite no consent and using physical interventions. Staff said they knew the person's needs well as they had delivered care to them for 11 months. There was no record of physical intervention training for staff which included the use of holding techniques. We reported this to the local safeguarding team for investigation.

Staff had neglected to provide appropriate care for one person's hands; their nails were long and dirty. We asked the person to open their hand and saw the long nails had caused indentations in the palm of their hand which was a risk of infection when they scratched their skin. They had not received adequate personal care and looked in a dishevelled state. Staff told us the person often declined personal care. However, there was an occasion when the person had requested a shower and hair wash the next day, but staff recorded they had a body wash instead. There was no reference made as to why the shower and hair wash was not

completed as requested. Hand and nail care had not been completed thoroughly for other people leading to the potential for injuries and infection when they scratched their skin.

One person who used the service told us they had a choking episode on 25 August 2016 and reported this to staff. During the inspection on 26 August 2016, we found the same person was given food at lunchtime which was contrary to health professional advice and which was a choking risk to them. Staff told us the person often chose to eat foods that were contrary to recommendations by the speech and language therapist (SLT). However, staff delivering meals to the person was unaware of the choking risk or of the consistency of food recommended by the SLT. We did not observe the person being offered an alternative at lunchtime or warned that the flaky pastry was contrary to the SLT recommendations'. In the evening, we observed staff had neglected to ensure the person was safely positioned in bed when eating their meal, which was a choking risk to them; inspectors intervened to ensure the back rest of the bed provided the person with appropriate positional support and told the registered manager.

There were also two incidents on other lodges where people had received bruises from the use of hoist slings that did not fit correctly; the people were reassessed and correct slings obtained for them. During the inspection on 9 September 2016, inspectors intervened on one lodge when we observed a person who used the service given a meal that was not consistent with their care plan and health professional advice. The meal provided was a potential choking risk for the person and when we discussed this with staff, they told us they had not been informed.

Not ensuring people were safeguarded from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We saw people who used the service had assessments completed which identified potential risks. These included falls, pressure damage to skin, moving and handling, nutritional intake, depression and changing behaviour. Some of the risk assessments were linked to care plans. For example, when a risk of pressure damage to skin was identified, the care plan stated what equipment was to be used to help mitigate risk. However, we found some of the risk assessments did not have adequate control measures, some were not linked to care plans and some had not been completed accurately. For example, one person had a high risk of depression and self-harm but when we checked the person's bedroom, we saw staff had not followed risk control measures. The risk of depression was not linked to any plan of care for the person to help guide staff in identifying ways to monitor their depression or provide support to them. A risk assessment for one person's nutritional needs had omitted important information about the need for textured meals; this had given an inaccurate score rating and potentially affected staff monitoring of the person's needs. On one of the inspection days, we saw staff were supporting a person who used the service during a change in their behaviour. Staff had not been equipped with appropriate skills to deal with the level of distress the person was experiencing. This posed a risk to the person and to staff. We saw one person did not have a monitoring chart in place to check their fluid intake and urinary output. This was specifically important for them as they had a catheter in situ and was at risk of blockages and urinary tract infections.

Not ensuring people received safe care and treatment by assessing and mitigating risk was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We found medicines were stored safely and recorded when they were administered to people. However,

people had not consistently received their medicines as prescribed. This was found mainly on Coniston lodge during this inspection, but since the last inspection in February 2016, there had been occasional errors on some of the other lodges. For example, we found one person on Coniston lodge had not received a prescribed laxative for 11 days and missed two doses of another medicine due to stock management. Another person had missed medication for two days as their supply was coded on their medication administration record (MAR) as out of stock. Two people had pain relief patches applied a day later than indicated on their prescription and another person had theirs applied eight hours late; there were no recorded ill effects for the three people this related to. One person had not had a specific medicine as prescribed for one day which resulted in them having to have an additional blood test. Some people had not had prescribed creams applied. A further check of medicines on the three residential lodges on 8 September 2016 found these were managed appropriately.

Not ensuring people received their medicines as prescribed was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There were insufficient staff on duty on Coniston lodge to meet people's needs. At the start of the inspection, there were 16 people who lived on Coniston lodge and the majority of them had complex health care needs. All bar one person required two staff to move and handle them safely and one person required three staff for this task. People who used the service, relatives and staff all commented that staffing numbers were insufficient to support people's care needs effectively. There had been moving and handling incidents, insufficient monitoring and in some instances a shortfall in care provision that could be attributed to not enough staff. Comments about staffing numbers from people who used the service on Coniston lodge included, "Not all the time [enough staff]; it can be bad on nights as sometimes there's only one carer and one nurse. Right after tea it can be crazy with me buzzing, [Name] banging and [Name] shouting; sometimes you have to wait 20 minutes" and "Sometimes it can be bad at mealtimes and I've had to wait for care or a bedpan. I don't like to ask staff as they are too busy feeding people." Their relatives said, "There is not enough staff on at night; there is often only two staff on. It's a skeleton staff from 9pm" and "Some days, no [not enough staff]; I feel a bit sorry for the staff." Staff rotas confirmed there were days and nights when the staff complement did not adequately meet people's assessed needs.

People who used the service in the residential lodges and their relatives also had concerns about staffing numbers at times. People who used the service said, "There should be more staff; they work hard" and "There's enough if they are all here." Some relatives thought there were enough staff but others said, "They [staff] don't chat; they are too busy looking after everybody", "Sometimes I feel they could do with an extra pair of hands, especially when people are eating" and "Staff seem busier and run off their feet but they still sit with residents."

A visiting health professional to one of the residential lodges said, "No, not enough staff normally but they are skilled."

Staff on Coniston lodge and the other residential lodges felt staffing numbers could be improved. Insufficient staff had led to occasions when the moving and handling care plan for one person was not adhered to which posed a risk for them and for staff. Other staff said they were often asked to work on different lodges to cover short-notice absences, so individual lodges may start the shift with appropriate numbers of staff but this changed. Staff said they did not always have time to read care plans. Comments from staff included, "I feel we need more staff but BUPA is looking into this; quite a few have left", "Now and again, staff move across lodges; it's a bit of a struggle but we manage", "Some people need reassessing as

their needs have increased and care is more time-consuming. This impacts on your ability to care for other people", "Staffing levels are very stressful" and "It's too much. There are not enough [staff]. Bilton is very demanding and for instance [Name] should be on one to one care."

Not ensuring sufficient numbers of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

During a check of the environment, we saw some medical equipment on Coniston lodge was not in a clean condition and ready for use when required. For example, nebulisers, used to help people inhale specific medicines, and a syringe driver, had been stored in a dirty condition and a suction machine had not been checked ready for use for two months. The treatment room on Coniston lodge was disorganised and the air conditioning machine and top surface of the fridge required cleaning. We found staff had left a catheter bag full of urine on a person's bedroom floor and some commode pans had not been thoroughly cleaned. There was some equipment in other lodges that required replacement such as over-bed tables which had exposed woodchip making them difficult to clean; some wardrobes and under sink boards in bedrooms were in a similar condition. These issues posed a risk of infection to people who may already have compromised immune systems. We saw specific staff were allocated the role of 'infection control champions' to monitor staff hand hygiene and good practice when supporting people. Staff could raise issues with them to discuss with management and meetings recorded how practice could be improved.

Not ensuring good infection prevention and control measures was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We saw new staff were recruited safely with employment checks carried out prior to them starting work at the service. These included application forms, [used to gain information about previous experience, qualifications and to check gaps in employment history], references, disclosure and barring service (DBS) checks and an interview. The DBS checks looked at any previous criminal convictions and helped to assess candidate's suitability to work in care settings. There was a system for checking qualified nurses were registered with the Nursing and Midwifery Council (NMC) and that there were no restrictions on their practice. We found one member of staff's application form was not clear about the dates they worked for other organisations and this could have been checked out more thoroughly by the person completing the recruitment process. There were also gaps in new staff's probationary checks which meant initial and on-going monitoring had not always been completed. The regional director told us they would check this out.

Moving and handling equipment such as hoists, bed rails and sensor mats, call bells and fire safety items and systems used in the service were well-maintained and serviced appropriately. Maintenance personnel carried out checks on hot water outlets and fire alarms. They were available to make repairs to items when required.

Inadequate

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 application procedures for this in care homes 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 consent was not always sought in accordance with MCA and its principles were not always followed where people lacked capacity to give consent. For example, one person on Coniston lodge had been assessed as having variable capacity to consent to care and support and a best interest meeting form had been completed. The documentation was incomplete and did not fully include who had contributed to the decision; there was also one part which was inaccurate. It also had no discussion about how care was to be carried out using least restrictive options and whether physical interventions would be required. A DoLS had been applied for but not authorised, which meant the physical interventions carried out by staff were unlawful. A representative of the Supervising Authority, which was Hull City Council, told us they had concerns about the completion of MCA/DoLS documentation by staff; a large number of applications for DoLS had been made. They said their advice regarding DoLS applications and updating a person's care plan regarding the restrictions placed on them had not been followed. There were also examples where written information regarding MCA documentation was unclear in the residential lodges. For example, a best interest decision form for DoLS for one person did not evidence involvement of the donee who had lasting power of attorney for them which was required under MCA.

In one of the care files we assessed on the residential lodges, we saw the person had a 'do not attempt cardiopulmonary resuscitation' form in place which had been completed whilst the person was in hospital. The form indicated the decision was to be followed up and discussed with relatives but this section was blank. It was unclear whether the decision had been followed up and whether it reflected the person's wishes. There was no date arranged to review the decision.

Not acting in accordance with MCA and DoLS regarding consent for people who lacked capacity was a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

In discussions with staff on the residential lodges, they described how they sought consent before care tasks and what they would do to reassure people if they initially declined care. They said, "We would make seniors aware and talk calmly to the person, explain why we need to do the care and offer reassurance – build up a rapport with them; sometimes another carer may help" and "Ask people, we know our service users and how

they give non-verbal consent such as a thumbs up sign or a nod of the head."

We saw people had access to health care professionals such as GPs, district nurses, dieticians, speech and language therapists and physiotherapists. Ambulance crews were involved in transporting people to hospital for routine appointments. A health professional visiting one of the residential lodges told us staff had taken on board their instructions regarding positional changes for their patient and staff contacted them if they had concerns. However, we saw from observations of practice that advice regarding treatment was not always followed by staff. For example, one person required pillows to support their contracted limbs, as advised by a physiotherapist, but did not have them in place. Staff had told us the person declined to have them but they accepted the pillows when an inspector asked if they could be provided and, when we checked later, they remained in place. A physiotherapist had advised the use of a standing hoist for one person but staff were using a full hoist.

Other people had specific instructions about the texture of their meals to prevent them from choking but on two occasions during the inspection we saw the people had been provided with food which was not the correct texture. Similarly health professionals had advised on correct posture when eating meals but we observed this was not adhered to for one person. Two relatives told us they had raised concerns about how their family members were positioned either when in bed and eating a meal or sitting in a chair with a contracted arm not supported. We observed an ambulance crew had to wait 20 minutes for staff to support a person to be ready for their hospital appointment. The crew told us that waiting for approximately 15-20 minutes for the person to be ready was a regular occurrence. The appointments were three times a week and roughly the same time; not having the person ready caused delay for the crew and an extra wait for another person who had been collected and was waiting on the ambulance. Staff told us the person often declined to attend and they had to spend time encouraging them to get ready.

Not actively working with other health care providers who share care and treatment of people was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

In discussions with people who used the service and their relatives, they described how staff contacted doctors and community nurses when required to assess their needs and to receive treatment.

We saw the menus provided people with choice and alternatives. People spoken with were complimentary about the food provided to them. Staff were observed supporting people to eat their meals in an appropriate way and at a pace which suited their needs. However, there were some instances when people's fluid and food intake had not been managed effectively. For example, on Coniston lodge, one person had consistently not been provided with sufficient amounts of fluid to maintain their health. Another person was recorded as losing a significant amount of weight in three weeks but active monitoring of their food and fluid intake was delayed. The person had been unwell and staff had sought advice and a GP had visited on four occasions. However, staff had no record of what the person was actually eating and drinking during this period when they were unwell. This knowledge may have prompted them to weigh the person sooner and refer to the dietician in a more timely way. Some people had not always been provided with food at the correct texture to meet their needs.

Not ensuring people's nutritional and hydration needs were met was a breach of Regulation 14 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People who used the service told us they enjoyed their meals and there was plenty of choice and alternatives. Comments included, "I can ask for what I like; I get my vegetables and there are two choices." "I'm on a soft diet; someone came to talk to me about food. I sit where I like and usually choose to eat in my chair" and "I think the food is lovely."

The training records indicated staff had access to a range of training considered essential or 'mandatory' by the registered provider. These were completed during a five-day induction and updated at intervals. The induction included the Care Certificate, which is a set of standards that social care and health workers were expected to adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

There was a training manager based at the service and they maintained a log of who had completed essential training and when updates were required. We were concerned that despite receiving training, staff had not always put this knowledge into practice. For example, staff had received moving and handling training but there had been incidents which caused skin tears and bruising to people. A member of staff had hoisted a person from the floor following a fall and had not checked them thoroughly for injuries; the person had fractured their shoulder. Staff had received training in MCA/DoLS but there were concerns some staff did not fully understand the legislation. Staff completed training in 'managing behaviours that challenge' which provided them with skills in how to divert people's attention and deflect oncoming blows but was not designed to equip staff for the use of physical interventions. However, we saw there had been times when staff carried out physical interventions with people which placed both the person and staff at risk of harm and were unlawful. In discussions with staff, they described the use of holding techniques when supporting specific people but there was a concern that they did not fully understand that their actions in supporting them constituted a physical intervention or 'restraint'.

In one of the residential lodges at the time of the inspection, staff were supporting one person who was experiencing heightened anxieties. Some staff told us they felt ill-equipped to deal with the more complex changing behaviours that the person experienced and their training did not cover all the areas they required.

Not ensuring staff fully understood the training they received and carried out their duties in a competent way was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Relatives visiting the residential lodges told us they felt staff knew how to look after their family members. They said, "They know how to react to people", "They seem to be [well trained]", "I saw staff reposition them using appropriate equipment" and "They are good at comforting and caring especially when they [people who used the service] are distressed." Two people who used the service said, "Yes, they understand me" and "They have been taught well to do what they do."

We saw there was a list which detailed the names of staff who were able to give first aid to people. This included three care staff who worked night shifts and five care and three ancillary staff who worked day shifts. The regional director was asked to check that each shift, day and night, was covered by a first aider. There was additional training for nurses to ensure they maintained their registration requirements and also training in some of the conditions affecting the people who used the service, for example, catheterisation, wound care, diabetes, end of life care and Parkinson's Disease.

Supervision meetings were held and appraisal of staff was completed. However, there were inconsistences between the lodges regarding formal supervision meetings and some staff told us they had not had them for

some time. Staff did tell us they felt able to raise concerns with the unit manager in each of the lodges and they felt they were supportive of them.

Requires Improvement

Is the service caring?

Our findings

We observed instances on Coniston lodge when staff approach could be improved to ensure consistency when supporting people. For example, an inspector had knocked and entered one person's room to speak with them and noted their sheet was ruched up and they were lying half on the plastic mattress. A member of staff arrived with the person's lunch and described what it was to them, asked the person to raise the back of their bed rest, which they could do independently, and sat down next to them to assist them to eat their meal. They didn't ask the person if they were comfortable or whether they wanted the sheet adjusted before the start of their meal. Similarly, on Coniston lodge, we saw one person was in a dishevelled state, with their hair matted and staff told us they often declined personal care. Records indicated they had not had their hair washed for several weeks and they had requested a shower on a specific day, however they had a body wash this day instead with no explanation why their request was not carried out. There was no record of how staff attempted to build up relationships with specific people in order for them to feel comfortable in accepting care. Staff told us one person would accept personal care from a specific member of staff but they had left which had caused difficulties. There was no management review and professional advice sought of how personal care was delivered to this person despite the care causing them distress and anxiety.

On some of the residential lodges, there was little opportunity for quiet time for people unless they remained in their bedrooms. The televisions were on in the background all the time despite people not always watching them. On one lodge we observed a member of staff changed the television channel, which was set as a radio station, but there was no consultation initially with the one person sitting in the vicinity of the television. They changed the channel to a television setting and mentioned to another member of staff that they [people who used the service] wouldn't like the specific programme which was due to come on. The staff then turned to the person sitting near the television and asked what type of programme they would want to watch. We also observed one person had just dozed off after their breakfast; a member of staff woke them up and asked them if they were comfortable.

People spoken with on Coniston and the residential lodges told us staff were kind and caring towards them. Comments included, "They are all very nice; they are nice people and if you have a problem you can go to them", "The staff are all smashing; they are helpful, speak nicely and listen", "I'm looked after well; they ask if there is anything the matter with me. I go to bed when I want", "They are kind and very good to me; they always knock and cover me with a towel [during personal care]" and "They don't ignore me at all and they listen to me. The staff are caring."

Relatives also praised the staff in their comments to us and some reported staff provided support and reassurance to them. They said staff kept them informed about their relatives. Comments included, "They work well with residents and respect their dignity and care", "The staff are kind and care well for residents", "Dad was here until he died; coming here extended his life. He came for respite but didn't want to go home. Once mum came here, they regained their relationship", "The staff are friendly and helpful", "She is looked after well; I have no concerns or worries", "Could not be better [care]", "Mum is fond of lots of staff; some have a more gentle approach than others", "Usually she has a big smile on her face when I arrive; I love

coming and have a good banter with them [staff]. They [staff] were lovely when dad died" and "Mum is looked after well but they need to support good recruitment and ensure continuity of staff. Most are caring but the attitude of others, which have since left caused disappointment."

A visiting health professional said, "I have never seen anyone being disrespectful" and "All staff were very helpful."

We looked at comments from compliments cards and saw these indicated staff had shown compassion and kindness to people who used the service.

During the inspection visits on the residential lodges, we observed many occasions when staff treated people with dignity and respect, offered choices, spoke to them in a kind and patient way and comforted them when they were distressed. For example, staff assisted people to eat their meals in an appropriate way, they offered several choices of meals, some of them visual, when options were declined and asked them if they wanted second helpings of each course. Staff assisted people with their mobility when required and ensured those who were independent were supervised from a distance. Staff ensured items were within people's reach when they were sat in bed or in a chair in their bedroom. We saw staff adjusted people's clothing when required in a discreet way. During administration of medicines, the senior spoke to people, explained what they were doing, engaged with people using their first names and used a different approaches for specific people indicating to us, they knew their needs well.

We observed staff were attentive to people's needs. For example, we saw a member of staff support a person when they were upset; this was completed in a gentle way and the member of staff put a reassuring arm around the person which was a comfort to them. The staff spoke to people about their relatives, engaged with them, gave eye contact and listened to their replies. Staff noted one person was moving their wheelchair away from the dining table using their feet; they approached the person, assisted them to put their feet on the foot rests, pointing out they could hurt themselves and asked them where they wanted to go. The atmosphere on the residential lodges was calm, pleasant and homely.

In discussions with staff, they described how they would promote privacy and dignity and how they would help people to remain as independent as possible. Some staff had been allocated a role of 'dignity champion' to monitor practice and advise on ways of improvement. Comments included, "We knock on doors and keep them and curtains closed during personal care", "We keep them covered with a towel [during personal care]", "Use their preferred name and not 'pet' names", "Treat people as if they were your relative", "Make sure people have choices about clothes and food and try to get them to do things for themselves and observe that this is done safely", "We adjust people's clothing to observe dignity" and "I give options, for example a bath or a shower; it's their choice and not for ease of delivering a service." Relatives said, "Their personal hygiene is lovely; she is always in clean clothes with hair and nails done", "She is always clean; they take her to the toilet and they treat her with dignity. They know her likes such as her jewellery and they make her laugh" and "They are sometimes incontinent but they [staff] treat her with dignity and talk to her nicely."

People who used the service were provided with information. There were notice boards containing information about who was on duty, what activities were planned and what the meals were for the day. There was a service user guide, which described the services available and how people could raise concerns. We observed staff provide people with explanations prior to carrying out tasks such as moving and handling or supporting them with meals. These measures helped to keep people informed and enabled them to make decisions about their daily living activities.

Staff maintained confidentiality. Conversations about personal issues or phone calls made with professionals were carried out in the offices on each lodge. Staff files were held securely in the main administration lodge. Care files were held securely in lockable cabinets and cupboards. However, we found a large box of people's personal records stored in an unlocked cupboard in the corridor on Coniston lodge; we mentioned this to the registered manager to make secure.

Requires Improvement

Is the service responsive?

Our findings

We found how staff responded to people's needs had been inconsistent. We found staff had not always assessed people's needs fully and there was a lack of recognition about how their medical condition impacted on their care and support needs. We found some risk assessments lacked important control measures and some did not provide sufficient guidance for staff

Care plans lacked important information and there was the potential for care to be overlooked. For example, on Coniston lodge, two people's care plans lacked guidance in how staff were to support with their personal care needs, people who had hand and leg contractures had no plans of care for how these were to be supported, there were no care plans to guide staff in nail care for specific people and care plans to manage catheter care lacked clear direction to ensure they remained patent. There were gaps in some people's wound care plan and re-dressing times were not always followed. One member of staff said, "I wash and dry their hand in stages and put a crepe bandage in their hand – I'm not sure if this is right."

On the residential lodges, two of the care files we looked at contained short-term care plans for people; we saw these did not contain adequate guidance for staff in how to support the people and meet their needs. For example, one person had a catheter, which often blocked and they were prone to urine infections; the short-term care plan had no mention of how catheter care was to be managed. The short term care plan was more of an assessment of people's needs. The regional director told us in the instances when people were admitted for short-term care or decisions about permanent residency had not yet been made, additional care plans sheets were supposed to be completed to augment the information in the short-term care plan document. We found this had not happened sufficiently to guide staff. However, in discussions with staff, they were able to accurately describe the person's catheter care needs and how they met them.

One person's care plan lacked full guidance in how to manage their behaviours which were challenging to staff. Also other people who had changing behaviours lacked a thorough care plan to guide staff in how to manage them in a consistent way which was safe for the person and for staff.

We found there were times when person-centred care had been inconsistent and staff had not been fully responsive to people's changing needs. For example, with one person's hydration needs, two people's choking risks, one person's weight loss, one person's self-harm risk, one person's fall from a chair, people's seating positions and general hand and nail care. A relative told us they had asked if the family could pay for a carpet in one person's bedroom to help cushion falls; they said no decision had been made yet and the request was six months ago. Another relative told us their family member on Coniston lodge had not been able to have a bath for over six weeks as they were waiting for a new sling. Staff commented about this and said, "We bruised their legs and chest with the sling; we need a different sling before we can bathe them – it has been weeks."

However, there were other times when staff had responded quickly to people's changing needs. For example, staff had alerted a person's GP and community psychiatric nurse when they became very distressed and attempted self-harm. Staff contacted emergency services and crisis intervention team

quickly for another person during a heighted anxiety episode. Staff had called emergency care practitioners when people sustained falls and skin tears. Staff had ensured one person had medicines in liquid form as they had difficulty swallowing tablets. A relative told us, "Staff had difficulty with their tablets so they got them all in liquid form and it is much better for them."

We looked at how people's care was evaluated each month. Staff commented on changes that had occurred but this was not consistent and some evaluations missed reporting on incidents the previous month. The information in evaluations was also not always updated in the care plan so staff would have to read through pages of evaluations to see when changes had been made. Similarly advice and treatment from professional visitors such as physiotherapists and speech and language therapists was included in 'professional visitors logs' or letters following visits, but the information was not always added to the care plans. This meant there was a risk of updated information about care and treatment not being readily available to staff in care plans.

Not ensuring people's needs were assessed and care was planned and delivered in a consistent and person-centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

In discussions with staff, there were able to describe how they responded to people's changing needs and how they monitored them. For example, how they recognised the signs of a urinary tract infection or the start of a pressure ulcer and what action they needed to take.

We saw that as part of care plan delivery, staff completed monitoring charts for people's nutritional intake, their weight, pressure relief and behaviours that could change quickly. There was inconsistency regarding the completion of some of the charts. For example, staff did not always include the amount of food given to people and we saw there was no fluid intake and output monitoring for a person with a catheter which had management difficulties. A visiting professional told us, "Record keeping could be improved as charts are not always filled in."

We saw there was a lack of stimulation for people who lived in Coniston lodge; there were a few activities arranged by the hostesses, whose primary role was to serve meals. Some people on Coniston lodge went to the residential lodges to join in activities there but most people either stayed in their bedrooms or watched television and listened to music. There were very little activities recorded for people who were nursed in bed.

There was a different picture regarding the provision of activities for people on the residential lodges. Activity co-ordinators organised in-house activities such as games, themed parties, reminiscence, one to one and group discussions, gardening, nail manicures, quizzes, craft work, sing-a-longs and visiting entertainers. There were also trips out to local venues such as pubs, parks and community facilities. There was a 'resident and relative committee' who were involved in meetings to discuss and plan activities.

There was a complaints procedure on display in the service and this was provided to people in a 'service user guide'. The policy and procedure described timescales for acknowledgement, investigation and resolution. It also provided information of where people could escalate complaints if they were unhappy with the outcome of an investigation. Staff knew how to manage complaints. People who used the service and their relatives told us they would feel able to raise concerns in the belief they would be addressed. One relative had made complaints about two separate issues; on letters to them for both complaints, we saw their name and that of the person who used the service had two different spellings – both incorrect. Also the tone of some response letters could have a more customer focus approach. This was mentioned to the

regional director to address.

Inadequate

Is the service well-led?

Our findings

Throughout this inspection report we have indicated concerns and a number of regulations have been breached. Failure of the registered provider and registered manager to comply with specific Regulations 7, 9, 11, 12, 13, 14, 17 and 18 is a breach of Regulation 8 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

During the comprehensive inspection visits, we had concerns about the lack of management oversight to ensure people received the care they required and staff received sufficient support. The level and amount of concerns we found on Coniston lodge prompted us to take urgent action. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We asked to see specific supervision records, investigations the registered manager had completed into incidents and observations of care practices when staff supported one person who used the service but these could not be located.

We saw the induction process for new unit managers did not provide sufficient support for them. The induction records showed new unit managers had completed the basic Care Certificate and essential training such as moving and handling and safeguarding people from abuse, but there was no plan to equip them with what was expected regarding managing the lodges.

We found shortfalls in management knowledge about mental capacity legislation, consent and physical interventions. There were also concerns about how Deprivation of Liberty Safeguards documentation was completed and checked by management ready for submission to the local authority.

There were mixed comments from relatives and staff regarding the overall management of the service. There were positive comments about the registered manager's availability when support was required but also other comments about their approach and how this was not consistent with all the staff team. Staff and relatives reported that morale had been low and there had been lots of staff changes which had caused concern for continuity of care. Most staff on the individual residential lodges told us they felt supported by the lodge managers and could raise concerns if required.

Not ensuring appropriate management of the service was a breach of Regulation 7 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a quality assurance system which consisted of collecting information from audits. The information was inputted into monthly reports [quality metrics] completed by the registered manager and forwarded to the registered provider's quality team. This included information such as pressure ulcers,

infections, accidents, safeguarding referrals, weight loss, the number of deaths, the use of specific medicines, hospital admissions and complaints. The regional director told us the information could be six weeks old before the quality team were able to review it. We saw accidents and incidents were recorded and reported to the registered manager, however, there was no analysis to look for patterns and trends so that lessons could be learned; each accident and incident was dealt with in isolation. On one occasion when staff training was identified as being required, this was not checked to make sure all staff had completed it. In June 2016 there were 10 accidents and injuries and in July 2016 there were 17. There was a description of each incident but no full analysis and whether it could relate to other incidents or timings that could be a result of staffing issues. On Coniston lodge, it was identified in May 2016 for the need to update moving and handling training following several incidents which resulted in bruises and skin tears. When we cross-referenced staff on the rota with those who had completed the update, there were several staff still in need of the training update. Staff told us meetings took place to discuss incidents but said, "There is no learning from incidents at these meetings."

Similarly, staff reported the number of people who had urinary tract infections and chest infections but a spike in numbers in July, although documented, was not analysed to rule out potential causes, such as reduced fluid intake, catheter management or personal hygiene.

We saw audits were completed of care files. These commented on the presence of documents rather than the quality of what was written in them. We saw short-term care plans, for people admitted for respite or in the interim period before permanent residency was decided, lacked important information. The regional director told us these were supposed to be audited after the first few days of admission, but we saw this had not taken place. There were checks of the environment but we found infection control issues had been missed on Coniston lodge and some equipment such as over-bed tables in other lodges was in need of replacement and had been overlooked. There was evidence that medicines audits had helped to improve practice in the residential lodges but there had not been a medicines audit on Coniston lodge since May 2016 and we found some concerns re stock issues which had affected administration of them to people who used the service.

The registered provider had taken concerns raised at previous inspections seriously. Following the inspection in September 2015 when the service was placed in 'Special Measures', which meant it was monitored closely, the registered provider organised a 'Recovery Team' to provide support and oversight. We saw two reports of 'care and quality' visits completed in April and July 2016. The findings of visits had been linked to the Care Quality Commission's key questions, and risk and concerns were rated in line with a traffic light system. Both visits had recommendations and action plans for the registered manager and staff team to complete. The April 2016 report had rated the service as overall 'amber' and stated leadership and documentation had improved and interaction with people who used the service was good. However, the July 2016 report had rated the service overall as 'red' and the information included in it indicated improvements had not been sustained.

We found some concerns with communication methods. The registered manager held risk management meetings, daily short 'Take 10' [minutes] meetings to enable a representative of departments to discuss issues and there were staff meetings where people could make suggestions. There were also systems such as communication books, daily diaries to document appointments, notice boards and shift handovers to exchange information. Despite these methods, there were instances when staff on the units were not aware of important information. For example, the hostesses on Coniston lodge [who were responsible for serving meals] told us they were unaware of dietary requirements for specific people who used the service. This led to people being provided with food which was a choking risk. Care staff on another lodge told us they had not been made aware of a person's requirement for a textured meal and they provided them with food that

was a choking risk. Care staff were not aware of changes to one person's care plan and continued to use a full hoist when a standing hoist had been recommended.

Failure to have effective communication systems, good governance and management oversight and to ensure improvements were sustained meant the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following the first inspection date of 11 August 2016, we wrote to the registered provider telling them of our concerns about the number of incidents and accidents. When we visited on 8 September 2016, the regional director told us they had changed their procedures regarding accidents and incidents. Rather than waiting until the month-end to report the incidents and accidents which had occurred, the registered manager was to ensure the quality team were copied in to any notification sent to the local safeguarding team or the Care Quality Commission (CQC). This would enable the quality team to make contact with the service to check how they have managed the situation. The registered provider had also ensured closer senior management oversight in the form of visits to the service and an investigation had been started into why improvements noted at the inspection in February 2016 has not been sustained.

Staff were provided with a handbook which included a 'customer promise'. This described to staff their responsibility in ensuring they played a part in keeping this customer promise. The promise included support for people and their family, individualised care, ensuring people had a place they could call home and staff doing their personal best for them. The handbook also provided staff with information about what was expected of them and what they could expect from their employer.

There had been some surveys for people who used the service and results were on the notice board in a 'You said, We did' format. The results showed that people had been listened to and their suggestions acted upon.

The registered provider was aware of registration responsibilities in ensuring CQC received notifications of incidents which affected the safety and welfare of people who used the service; we received these in a timely way.

We saw the registered provider had produced a business continuity plan which described the measures staff had to take in any emergency situation such as flooding or utility failure. It gave details of locations that would provide temporary respite for people who used the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 8 HSCA RA Regulations 2014 General The registered provider and registered manager failed to ensure specific regulations, 9, 11, 12, 13, 14, 17 and 18 were met.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people received care that was person-centred and met their needs.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not acted in accordance with the Mental Capacity Act 2005 in relation to when service users were unable to give consent because they lacked capacity.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured care and treatment was provided in a safe way for service users by: - 12 (2) (a) (b) assessing and doing all that is reasonably practicable to mitigate risk. (g) the proper and safe management of medicines. (h) assessing the risk of and preventing, detecting and controlling the spread of infections. (I) working with other professionals when responsibility for care and treatment of service users is shared.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to ensure service users were protected from the risk of harm, abuse and improper treatment.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to ensure safe levels of hydration for one service user and safe management of nutritional intake for others.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered provider had failed to ensure adequate systems were in place to assess, monitor and improve practice.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager failed to evidence they had the necessary competence and skills to manage carrying on of the regulated activities so that people received safe, effective, caring and responsive care and to ensure the service was well-led.

The enforcement action we took:

We decided to cancel the registered manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet service users needs.

The enforcement action we took:

We decided to take urgent action to remove the regulated activities of Treatment of disease, disorder and injury and Diagnostics and screening services. We also decided to take urgent action to vary the condition of the registered provider's registration so they could not provide nursing care.