Review of compliance

Quality Care (EM) Limited The Oaks Nursing Home	
Region:	East Midlands
Location address:	114 Western Road Mickleover Derby Derbyshire DE3 9GR
Type of service:	Care home service with nursing
Date of Publication:	May 2012
Overview of the service:	The Oaks is registered to provide the regulated activities of accommodation for people requiring nursing or personal care, treatment of disease, disorder or injury and diagnostics and screening. It provides care for up to 28 people of either gender who have Dementia.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Oaks Nursing Home was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether The Oaks Nursing Home had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 12 - Requirements relating to workers
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 19 January 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and reviewed information from stakeholders.

What people told us

We carried out this review to check compliance with a warning notice previously served, and were concerned that there might be continuing breaches of the regulations. Where areas of non-compliance were identified during inspection they are being followed up and we will report on that action when it is complete.

Most of the people who live at The Oaks Nursing Home would find it difficult to help us understand their views about the quality of the care being provided to them. We used a special tool designed to help us understand how people who have Dementia experience the care being provided to support them. We carried out our observations in two lounges and in the dining area over the lunchtime period. We looked at how staff interacted with people and how care was being provided to support people with their needs. We looked for clear and observable signs which would show us how people felt about the care they were receiving.

We found that in spite of some slight improvements, people were still not being treated

with the respect and dignity they deserved. With one or two exceptions, we did not see many staff really attempt to communicate effectively either verbally or by using touch to reassure people. During our inspection we saw that people using the service appeared passive or withdrawn. We did not observe people smiling, talking or laughing, apart from when we instigated it, which shows that it was possible to engage with people living at the service.

We were very worried about how people were moved and handled and we witnessed one person sustain a serious injury following an unsafe manoeuvre. We were concerned about how staff managed restrictions to people's freedoms which had been assessed under the Deprivation of Liberty Safeguards. This law is part of the Mental Capacity Act 2005. It aims to protect people who do not have the capacity to make their own decisions about their lives and care from unlawful restraint.

We found the staff were still not safely recruited or effectively supervised, this meant that the care being provided was not of good quality and safe. We found that the providers and manager failed to have effective systems in place to identify, assess and manage the risks to people's health safety and wellbeing. We were concerned that improvements could not be sustained.

What we found about the standards we reviewed and how well The Oaks Nursing Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People were not treated with dignity and respect.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People did not receive safe, effective care which met their needs in accordance with their preferences.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People were not protected from abuse or the risk of abuse and their human rights were not being recognised and respected.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The recruitment procedures continued to be unsafe and the manager could not be assured that the people who were working at the service were suitable to work with vulnerable people.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff did not receive effective supervision or appraisals of their competence necessary to bring about improvements in their work performance. This meant that people could not be assured they were safe and had their needs met by competent staff.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People did not benefit from safe, good quality care, treatment and support. This was because the systems to manage the risks to people's health, welfare and safety continue to be ineffective.

Actions we have asked the service to take

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are major concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We set a compliance action following our last visit to the service in this outcome area. We found evidence to show this had not been complied with.

We saw some members of staff were reassuring when assisting people and we observed that they made sure people were covered when they were moved to maintain people's dignity. We also saw staff offer people choices in terms of what to eat and we saw some people being offered and provided alternatives when they did not want to eat the food provided.

However, we still saw many examples of poor practice. In one lounge, we observed staff wake up a person who had been asleep in a chair for twenty minutes. Staff told the person it was time for lunch and then helped them out of the chair manually within a few seconds of waking them. The person still had their eyes closed and was still not fully roused, as staff had not given them chance to wake up. The person appeared startled and confused about what was happening. This showed that staff did not understand or respect the fact that people needed time to come round after being woken from their sleep and to re-orientate themselves to their surroundings. This is especially important for people who have Dementia as they struggle to orientate themselves because of the nature of their illness.

We observed a member of staff who was supervising the lounge did not interact with people seated nearby and spent the first five minutes sitting at the end of the room away from the people living at the service. After five minutes, the staff member went over and held the hand of one person who responded to this and became more alert. During lunchtime we observed staff made an attempt to communicate with people; in most cases this lasted for a very short period of time, and staff quickly lapsed into silence when assisting people to eat. We also saw one member of staff was consistently looking around the room whilst assisting someone to eat. This showed that the staff member was not concentrating on the person they were assisting. These examples showed that staff still did not understand the need to communicate and interact with people using the service to provide them with reassurance and an appropriate level of care and support.

We found that in spite of some slight improvements, people were still not being treated with the respect and dignity they deserved.

Other evidence
We spoke with the local authority contracting and procurement team before we visited again. They had visited the service three times since our last inspection. They told us that after initial improvements, they found in December that the improvements were not sustained and further concerns were raised. Following their visit in January, they informed us there were ongoing concerns in this outcome area; people were still waiting a long time for their lunch and people were still reported to be wearing each other's clothing because of errors made with returning laundry.

We were unable to communicate directly with the person responsible for the service from the primary care trust, but they have visited the service since our last inspection to assess the quality of care. We have not received a copy of their report so cannot comment on the findings.

We looked at the supervision records of the staff we were concerned about following our last inspection. We saw evidence that issues of privacy and dignity were raised with them in supervision. In one case we saw that the person's practice had been observed and was found to be improving. The manager provided us with evidence to show that all staff had received training on issues of privacy and dignity. The staff we spoke with confirmed they had undertaken this training.

However, we found evidence in other records to show that there were ongoing issues with how staff responded to people living at the service. For example we found comments in quality assurance surveys to indicate that people were not being treated with respect and dignity. Some of the concerns which were recorded were about staff not paying enough attention to shaving people, not checking the people's glasses were clean, not checking that people's hearing aids were working first thing in the morning and not checking that their teeth were cleaned with toothpaste. Others raised concerns about their relatives being dressed in clothing belonging to other people, about them being cold and being over sedated. These are basic issues which are essential to making sure people are treated with dignity and receive good quality care.

We also found several references in records to staff using mobile phones whilst assisting people with their care and during training courses. In spite of this issue being raised by the manager in memos and at staff meetings, we heard a staff member's

mobile phone ring whilst they were assisting people with lunch and we saw a member of staff take her mobile phone from her pocket to check the time on the day after our inspection. This showed that staff were not concentrating their full attention on the people they were employed to care for. It also showed that staff were failing to follow directions issued by the manager of the service.

We also found evidence that concerns had been raised with a staff member during supervision about issues of dignity and privacy. We found the same issue was raised again during the following supervision session with no evidence that any action was being taken to address this issue. This showed that issues of concern in terms of people being treated with dignity and respect were not being taken seriously and no steps were being taken to address this behaviour.

Our judgement
People were not treated with dignity and respect.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We set a compliance action in this outcome area following our last inspection of the service. We found evidence to show this had not been complied with.

We were extremely concerned about the way we saw two staff move and handle people living at the service. We witnessed them routinely forgetting to apply brakes to wheelchairs and saw the wheelchairs slipped away from people as they were being transferred into and out of them. This is extremely dangerous practice and could easily result in falls. We also witnessed some very poor practice when they prepared to move a person using a hoist. We saw them trying to get a sling around the person who was seated. They pushed and pulled the person roughly, lifting her legs and pulling her arms and pulling her forward. This could easily have resulted in bruising. There was minimal conversation either prior to or during the manoeuvre and the person was obviously distressed and very angry about how she was being treated. We saw her shout at staff, asking them what they were doing, swear at them repeatedly and hit out at them. This incident could have been avoided had the care been delivered in a safer and more appropriate manner. Please see outcome 7 – safeguarding.

We observed lunch in the dining room. We saw that everyone had their meal served on a plastic plate, regardless of their needs or preferences. This shows the staff did not take these issues into account when considering what made dining a pleasant experience. Some people using the service needed assistance to eat their meal. We saw that two people struggled to eat their meal as the food kept sliding off the plate or their cutlery. We saw no evidence that they had been provided with specialist

equipment such as plate guards or cutlery to help them to eat independently. This shows that this aspect of their needs had not been considered and provided for.

The dining room was limited in space and everyone sat down to eat at the same time. We saw that some people had to stand up from their meal to allow other people to pass whilst they were in the process of eating. This interrupted their dining experience and could affect their appetite as it happened repeatedly. We saw that one person had their chair right up to the wall and the table pushed up to them and could not get out of their chair as there was not enough room. This could have the effect of making them feel restricted in their movements which may have been uncomfortable and distressing.

We saw that there was a choice of two meals for lunch and these were displayed on menus on the tables. We saw that people were asked prior to the food being served which option they wanted and alternatives were provided if requested. One person had chosen the corned beef hash and we saw this looked quite watery in appearance. We spoke with this person and asked if they were enjoying their meal. They told us, "I don't like it, it's sloppy." They told us they would prefer to try something else and staff facilitated this.

With one or two exceptions, we did not see many staff really attempt to communicate effectively either verbally or by using touch to reassure people. During our inspection we saw that people using the service appeared passive or withdrawn. We did not observe people smiling, talking or laughing, apart from when we instigated it, which shows that it was possible to engage with people living at the service.

Other evidence
We spoke with staff about the needs of a person using the service in relation to their nutrition. The staff we spoke with had a good knowledge of the care and support this person needed. We asked staff about the care plans of people using the service and they told us the nurses were responsible for recording information in the care plans and on daily logs. Staff told us they had been encouraged recently to read some care plans to ensure they knew the needs of people using the service. As our observations show, this did not mean that people received the help in the way that it was planned.

We saw evidence in care plans to show that experts were requested to assess people and to offer treatment for their health. We saw that there were comprehensive plans in place to show what was needed to keep people safe and meet their needs. However, we found the staff were not following these. For example, we looked at the plan of a person who had sustained a serious injury. The care plan said the person mobilised using a zimmer frame and needed to be offered reassurance and praise at all times when being assisted to mobilise. We did not see the person using a zimmer and the staff did not offer praise and reassurance. They seemed to be panicking as they moved the person and this showed in their tone of voice which could easily have communicated itself to the person concerned. We asked a nurse about the person's mobility needs and she said that the person refused to use it and so was supported manually. The care plan did not reflect this. This shows that this plan was not up to date, and staff were not providing care in the way the care plan suggested.

We found evidence in quality assurance surveys to show that some relatives did not feel they were given sufficient information about their loved one's health care needs. Four out of eleven relatives said they only "sometimes" felt they were kept informed of

their loved one's health care needs. One relative commented they would like, "to be informed if GPs or specialists visit and of medication given." This suggested this information was not automatically forthcoming. There was no action plan in place to show how these concerns would be communicated to the nurses or addressed.

We spoke with the activities organiser and they told us they now looked at care plans to find out the life history of people using the service so they could do activities which matched their likes and dislikes. They told us they included baking, board games, singing and arts and crafts. When we looked at the quality assurance surveys we found relatives were not always satisfied that there were enough appropriate activities for people living at the service. 1 relative said there "usually" were, 2 said only "sometimes," and one person said "never." There was no action plan in place to show how these concerns would be communicated to the activity organiser or addressed.

Our judgement
People did not receive safe, effective care which met their needs in accordance with their preferences.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We set a compliance action in this outcome area following our last inspection of the service. We found evidence to show this had not been complied with.

We were concerned about a moving and handling incident we witnessed which resulted in a serious injury to a person living at the service. During the lunch period in the dining area, we observed a person who was being transferred in a hoist by two staff. The staff failed to apply the brakes to her wheelchair before attaching the sling to the hoist and the chair was moving. This was unsafe. They struggled to get the person comfortable in the sling and in the process of moving her, they trapped her little finger. The staff involved did not seem to have noticed this. They placed the person in a dining chair and left. We saw the person start to cry as the staff left and she was holding her little finger on her left hand aloft and apart from her others. We observed another member of staff approached her, having noticed she was crying and they asked her what was wrong; she said the staff had hurt her finger and trapped it when moving her. The staff member reassured her and stayed with her for a short time, returning on several occasions to check if her finger was still hurting, which the person confirmed it was. We did not see her report the injury to anyone or to ask the nursing staff to look at the injury.

We spoke with the person and noticed that bruising had started to appear on her left hand. We later asked the nurse in charge if staff had reported any incidents that day which would need referring to the safeguarding team, or reporting to them and they told us they hadn't. This showed that staff were not reporting accidents and incidents to the nurses which may be considered to be safeguarding incidents. As a result safeguarding

referrals were not always made in line with local procedures. We made a referral to the local safeguarding team to ensure the safety and wellbeing of this person.

We saw a person being assisted to eat, the staff member asked the person if she was ok, and the person replied, "no I am afraid." The staff member asked her why and she said, "I can't tell you." The member of staff did not explore this any further with her.

We were concerned about how staff managed restrictions to people's freedoms which had been assessed under the Deprivation of Liberty Safeguards. This law is part of the Mental Capacity Act 2005. It aims to protect people who do not have the capacity to make their own decisions about their lives and care from unlawful restraint.

After lunch we saw a person ask a nurse if they could have a cigarette. The nurse explained the person had smoked a cigarette before lunch so should wait a while. The person sat and waited for ten minutes and then asked again. We heard the nurse tell them if they waited until 1.15pm they could have a cigarette. We observed the person waiting and watching the clock until 1.15pm when they asked the nurse again for a cigarette. The nurse was administering medicines and called across the dining room, "let me finish this you know what time you can have one." The nurse then went over to the person and spoke with them. We spoke with this person after the nurse and they told us they had now been told they had to wait until 2pm. The person looked anxious and uptight, and she told us being treated like this made her feel, "horrible." We spoke with the nurse and she told us they restricted the person's cigarettes to every two hours. We insisted the person be given another cigarette, as a time frame had been promised and the goal posts repeatedly moved which was not only unfair but which could be seen as deceiving the person to keep them quiet. This was done.

Other evidence
We spoke with the local authority contracting and procurement team before we visited again. They had visited the service three times since our last inspection. They told us that after initial improvements, they found in December that the improvements were not sustained and further concerns were raised. Following their visit in January, they informed us there were ongoing concerns in this outcome area; the concerns were about improving communication with staff about how to manage challenging situations.

We spoke with three staff and one nurse about how they safeguarded the people in their care. They all knew how to respond to incidents and allegations of abuse and all recognised what incidents and events would need to be referred under local safeguarding procedures. Some staff told us they would inform the nurse straight away and one told us they knew how to make the referral themselves. The nurse we spoke with told us they would make a referral for incidents and they had a good knowledge of what needed to be referred. We saw that all of the staff had received training on safeguarding vulnerable people.

However, in spite of this we saw from daily records that a nurse had observed one person using the service who had sustained skin tears on both shins. The nurse had written in the daily records that this had not been reported by staff. There was no evidence that an accident or incident form had been completed or that this unexplained injury had been referred to the local safeguarding team in line with local procedures.

One member of staff told us there had been a recent incident where two people who

live at the service had been "slapping each other." They told us they had reported this straight away to the nurse on duty. We looked at the records for one of these people and there was no evidence that an incident record had been completed or that this had been referred to the local safeguarding team in line with local procedures.

As can be seen from our observations, staff were not reporting injuries to the nurses which meant they could not be referred to the local safeguarding team in line with local procedures. This meant we were not confident that people were being protected from harm and abuse.

Our judgement
People were not protected from abuse or the risk of abuse and their human rights were not being recognised and respected.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are major concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We set a compliance action in this outcome area following our last inspection of the service. We found evidence to show this had not been complied with.

Other evidence
We spoke with the local authority contracting and procurement team before we visited again. They had visited the service three times since our last inspection. They told us that after initial improvements, they found in December that the improvements were not sustained and further concerns were raised. Following their visit in January, they informed us there were ongoing concerns in this outcome area; this was because staff who may have cautions or convictions had not been properly and fully risk assessed to make sure they were suitable to work with vulnerable people.

We looked at the recruitment files of six members of staff, three of whom had been recruited since we last inspected in September 2012. With the exception of one these were not satisfactory and there were insufficient checks to make sure staff were suitable to work with vulnerable people.

We could only find evidence of one written reference on the file of a member of staff who had been recently employed. This was written by a person who stated, "I have not seen this person for over three years so am unable to comment." There was no reference from the person's most recent employer. This meant the person was working at the service without two satisfactory written references.

The second staff file contained two written references, one was from a person who employed the person over two years ago and who therefore had no recent knowledge of the person or their work. The other stated, "I am a friend and colleague. I supervised this person years ago." There was no evidence that the manager had attempted to get a reference from a more recent employer despite the application showing the person had been employed at a company more recently. This meant the person was working at the service without two satisfactory written references.

We looked at the recruitment file of a member of staff who had worked at the service for a number of years. There was an incomplete criminal records bureau (CRB) check on file as some pages were missing. There was information on the CRB check which gave us some concerns. The Local Authority told us they had asked the manager to risk assess the person and for her to keep a copy of this assessment following their visit in January 2012. There was no evidence of the assessment being undertaken. This meant the manager had not assessed whether this person was suitable to care for the vulnerable people living in the home. The person had three references on file, all of which were written by healthcare professionals who stated they had worked with the person's relative. Two of the three contained no evidence that the referee knew the staff member personally, claiming only to know their relative. There were no references from a previous employer despite this person having been employed by other organisations. This meant the person was working at the service without two satisfactory written references.

We re-checked two of the files we were concerned about following our last inspection. This was to check that the areas of concern had been followed up and to make sure the files complied with the law.

Although some areas had been addressed in the first file; we found evidence that the file still did not comply with the law. We found that a reference we considered unsuitable during our previous inspection was still in place as one of the two required written references. The reference was not suitable as the referee was not the manager of the service the staff member had worked in. This meant that the manager of The Oaks would be unable to verify that the referee was who they said they were; she could not be certain that they were in a position of authority to be able to comment on the staff member's suitability to work with vulnerable people. There was also no written reason to indicate why the manager of the service the person was employed in had not been given as a referee. This indicated that no action had been taken to rectify the issues of concern we raised in relation to this reference.

We found that a second reference had been obtained from the person's former employer, but some of what was written about the approach and character of the person gave us concerns about their suitability to work with people who were vulnerable. We saw no evidence to prove that the comments had been discussed with the referee or with the staff member. There was no evidence that this information had been risk assessed to make sure that no risks were posed to the people living at the service.

We saw evidence in CRB check on the second file which gave us some potential concerns about the safety of people living at the service. We found no evidence that these had ever been discussed with the staff member, or of any risk assessment to show what measures were in place to make sure people were protected from potential

harm.

Our judgement
The recruitment procedures continued to be unsafe and the manager could not be assured that the people who were working at the service were suitable to work with vulnerable people.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are major concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We set a compliance action in this outcome area following our last inspection of the service. We found evidence to show this had not been complied with.

Our observations provided substantial evidence to show that staff were not providing care in line with the company's expectations and this was having a significant impact on service users. (See outcomes 1, 4 and 7.) This shows that the supervision arrangements were not effective or robust and that they failed to bring about the necessary improvements in the quality of the service being provided.

Other evidence
We spoke with the local authority contracting and procurement team before we visited again. They had visited the service three times since our last inspection. They told us that after initial improvements, they found in December that the improvements were not sustained and further concerns were raised. Following their visit in January, they informed us there were ongoing concerns in this outcome area; this was because there was evidence of a lack of effective supervision and a lack of disciplinary action in light of staff errors and behaviour.

We spoke with five members of staff during our inspection. They told us they had received training in understanding the needs of people who have Dementia and this included how to support people with challenging behaviour. They had also received training on safeguarding; on the Mental Capacity Act and on issues of dignity; the records we saw confirmed this. We asked three staff if they had received a formal supervision recently with a more senior person and they told us they had received

supervision in December 2011. They said that discussions had been held about how well they had understood the recent training given and had also addressed concerns which we raised in our last inspection in relation to staff. Our evidence in outcomes 1, 4 and 7 indicated that this had not been effective in bringing about improvements in the quality and safety of care being delivered to people.

The local authority told us they had concerns about a member of staff and several incidents involving medication. When we looked at the supervision records we found evidence that the person's competence to administer medication had been risk assessed. The quality of the risk assessment was very poor and there was no evidence to show how the manager would make sure the person was safe to administer medication or what checks would be done on this and at what intervals. We did, however see evidence that a competence assessment had been done on the person in relation to medication. This was dated 4 October 2011 and indicated the person was fully competent to administer medication.

We saw evidence that there had been a further incident concerning the safekeeping of medication when the person had been in charge of this aspect of care. This had happened in December 2011. We saw evidence that this had been discussed with the person in supervision and several actions had been taken to make sure the person was competent. The records indicated that a further competence assessment would be taken within four weeks (by 5 January 2012.) We could find no evidence that any further competence assessments had been done. The records indicated that any further incidents would result in further disciplinary action being taken.

The local authority made us aware that a further medication error had been made by the same person which was a very serious issue leading to a safeguarding referral being made. We could find no evidence that this had been discussed with the person. When we spoke with the person's supervisor she was aware of the incident, but confirmed that this had not been discussed in supervision. There was no evidence of any further risk assessment, assessment of competence or of any disciplinary action. This showed that the manager had failed to effectively assess the person's competence or to manage a known risk. As she had failed to do this people were placed at risk of harm.

We found further evidence to show the manager had stated her position to staff and then failed to follow this through. We saw evidence in staff meeting minutes and memos to staff to indicate that staff must not have their mobile phones on their person, or turned on whilst on duty. In these documents the manager made it clear to staff that if they were found to have their mobile phones on their person whilst on duty disciplinary action would be taken. As can be seen in outcome 1 we saw that on two occasions during our inspection staff had their mobile phones on their person and turned on whilst on duty. One member of staff was spoken with on the day of our inspection, but the manager defended the fact that she had her mobile phone on to us. Our evidence showed that the staff did not take the threat of disciplinary action seriously and continued to flout the position of the company in relation to mobile phone use.

Our judgement
Staff did not receive effective supervision or appraisals of their competence necessary to bring about improvements in their work performance. This meant that people could not be assured they were safe and had their needs met by competent staff.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We issued a warning notice to the providers and the manager of this service in this outcome area following our last inspection of the service. We found evidence which suggests there may be continuing breaches of this regulation.

Our observations in outcome 1, 4 and 7 have shown that there are serious and ongoing concerns about the quality and safety of care being provided to people living at the service. In spite of our previous warnings, we could find no evidence that the provider or manager had effectively monitored the delivery of care and brought about the necessary improvements. We could not find any evidence that there were any systems in place and operating effectively to make sure that risks to people living at the service were effectively managed. This placed them at risk of harm.

Other evidence
We spoke with the local authority contracting and procurement team before we visited again. They had visited the service three times since our last inspection. They told us that after initial improvements, they found in December that the improvements were not sustained and further concerns were raised. Following their visit in January, they informed us there were ongoing concerns in this outcome area; these were around the sustainability of improvements to the care being provided and concerns about the ability of the manager to make the necessary changes.

We spoke with three members of staff who told us the manager worked at the service full time and there was also a nurse on duty at all times and staff said they would report

any issues to the nurses or manager. As can be seen in outcomes 4 and 7 this did not happen in all cases.

When we inspected the service in September 2011, the manager told us that the company had just started using an audit tool. When we asked to see these audits, the manager told us the company were about to start using it, but had not done yet. We could find no written evidence that a representative of the provider (other than the manager who is also a director) had visited the service regularly to assess or monitor care. The staff we spoke with told us they had not been spoken to by anyone but the manager and the nurses. They said no-one from the company had spoken with them. One nurse told us a director had spoken with them and asked for suggestions on how the service could improve. There were no records to support this.

We saw evidence of more supervision of staff taking place, including direct observations of practice and competence assessments in some cases. These were not done rigorously, routinely or consistently. Our evidence indicates this had not been sufficient to bring about sustained improvements to the quality of care being provided.

We asked the manager for evidence of her audits. She showed us a quality assurance survey which she said had been undertaken following our last inspection. We saw that eleven surveys had been returned by relatives and that five had raised no concerns. As can be seen in outcomes 1 and 4 there was evidence that people had raised concerns in the other six cases. In some cases, serious issues about people's dignity, about information on people's health and about their care were being raised. We could find no evidence that any action plan had been developed to identify how improvements would be made in these areas. This demonstrates problems had been brought to the manager and provider's attention and no action had been taken to consider or address these.

The only other evidence of auditing the manager gave us was of a medication audit. This comprised a tick list of items to check in terms of medication. The record indicates that these audits were done in December 2011 and January 2012. There were no issues of concern raised and no action plan had been developed. This is in conflict with the evidence we found in outcome 14. One part of the list asked whether there were any reportable incidents to the Commission. The manager had indicated there were not. This is in conflict with information received from the local authority concerning a safeguarding issue following an error in medication administration. We were not notified of this incident, as the service is required to do by Law. Our evidence in outcome 7 indicates there have been other incidents happening at the home which should have been notified to us and were not. This showed that the manager was not complying with the law by failing to notify the Commission of incidents when required to do so.

Where areas of continued non-compliance have been identified during inspection they are being followed up and we will report on that action when it is complete'

Our judgement
People did not benefit from safe, good quality care, treatment and support. This was because the systems to manage the risks to people's health, welfare and safety continue to be ineffective.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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