Agenda Item

Report to:	**Adult Social Care and Community Safety Scrutiny Committee**
Date:	**27 October 2011**
By:	**Director of Adult Social Care**
Title of report:	**Care Quality Commission Inspection of Mount Denys, Hastings**
Purpose of report:	**To inform the Scrutiny Committee of the failure to meet required standards at Mount Denys, including the reasons why the internal quality monitoring systems were ineffective, and to set out the steps taken to address these issues**

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

1. **Consider and comment on the content of the report and measures in place to address quality assurance; and**
2. **Endorse the Action Plan and monitoring arrangements**

1. Financial Appraisal

1.1. The additional staffing, training, equipment and refurbishment identified for Mount Denys in response to the issues identified within the Care Quality Commission (CQC) inspection report will result in additional expenditure of £272,000. These additional costs will be contained within the overall revenue budget for the Adult Social Care Directly Provided Services.

2. Background and Context of the CQC Inspection

2.1 Mount Denys is a directly provided service (DPS) residential unit providing care for up to 31 older people with mental health problems, primarily suffering with a dementia-type illness. 20 beds are designated as long-term, with residents staying from a few months to 11 years. These service users have often come via psychiatric inpatient units or from failed community placements and are considered to have complex and challenging needs, which makes resettlement in the community problematic.

2.2 In addition, Mount Denys has eleven respite or short term care beds. Such beds would be used proactively on a rolling basis to support carers in sustaining their caring role at home. Increasingly, people are being referred to the service at a much later stage, often when the home situation has completely broken down. Long term beds which become available have been quickly filled by people who originally came into Mount Denys for respite or short term care, and whose behaviour make it unlikely to have a successful placement in the community at a reasonable cost.

3. Changes in CQC Registration Requirements

3.1 Prior to October 2010, Adult Social Care was regulated under the Care Standards Act 2000. Under the Act regulated services were required to meet National Minimum Standards. From October 2010, Adult Social Care was required to register under new legislation: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009. These new regulations replaced the National Minimum Standards under the Care Standards Act 2000.

3.2 Under the new Act, all service providers are required to comply with CQC's twenty-eight outcomes within which there are '16 Essential Standards of Quality and Safety'. These new standards focus on outcomes for service users, which mark the change from regulation primarily based on systems and processes to regulation primarily based on outcomes, i.e. the experiences service users have as a result of the care they receive. CQC has stated that it will now 'continuously monitor compliance with the standards as part of a more responsive, robust system of regulation, accompanied by new Enforcement powers'. The Commission will also use information it has about providers, including information from service users and their representatives, other organisations and regulators. The inspections will consist of short, focussed, unannounced site visits, with direct observation of care, rather than set piece inspections they undertook previously. Under the new Act, all providers will have to comply with the same single set of standards. This was not the case under the previous Care

Standards Act, for example, Domiciliary Care services worked to 27 Minimum Standards and Care Homes worked to 43 Minimum Standards.

3.3 All the DPS that were subject to regulation were re-registered with CQC as required and Registered Managers were put forward and approved for each of the services as the lead manager for that service by October 2010. Mount Denys was the first ASC home to be inspected by CQC since the changes in their regulation requirements in October 2010.

3.4 In August 2009 CQC inspected Mount Denys under the previous regulations and passed it as 'good'.

3.5 Following national publicity about CQC in the Bristol Winterbourne residential care case, CQC have developed a more forensic model in their inspections and our first experience of this new style of inspection was at Mount Denys.

3.6 An unannounced inspection by CQC took place at Mount Denys on 18 July 2011.

4. Summary of Key Issues CQC Found at Mount Denys

CQC identified four areas as a 'major concern'. (See Appendix 1 - Summary of the Enforcements and Appendix 2 – four CQC letters confirming Enforcement actions)

4.1 Failing to comply with Regulation 22: the registered person must ensure that at all times there are sufficient numbers of qualified, skilled staff

4.2 Failing to comply with Regulation 11: the registered person must make suitable arrangements to ensure services users are safeguarded against risk of abuse (allegations/incidents of abuse and prevention and responding)

4.3 Failing to comply with Regulation 9: the registered person must ensure that the service user is protected against the risks of treatment that is inappropriate or unsafe (carrying out assessments, care planning)

4.4 Failing to comply with Regulation 10: the registered person must protect service users ….by means of effective operation of systems designed to regularly assess and monitor the quality of services provided…

4.5 The above enforcements were issued by the inspectors stating that:

'During the visit, inspectors identified concerns that risk assessments were not completed fully, not reviewed regularly and were not used appropriately to inform care planning and care delivery.

'Proper steps had not been taken to ensure that the delivery of care ensured people living in the home were receiving safe and appropriate, personalised care, treatment and support.

'Suitable arrangements had not been made to ensure that people were safeguarded against the risk of abuse, or that allegations of abuse were responded to appropriately. Inspectors looked at records detailing a number of violent incidents involving people living at the home. This highlighted that there had been approximately 44 incidents of physical violence across all three units between people living in the home during this period. An additional 26 reported incidents of physical violence were recorded toward staff.' (CQC press report, August 2011).

13 regulations were also found to be non-compliant. (See Appendix 3 – the full CQC Report).

5. Reasons for Failure to Identify Lack of Compliance at Mount Denys

5.1 There are a number of factors that contributed to the failure to identify non-compliance of Mount Denys.

5.2 A new Quality Framework was introduced in November 2010 for compliance monitoring in DPS in response to the new regulations. This new compliance monitoring system was not fit for purpose. It focussed on a small range of outcomes each month which meant the full coverage of all CQC outcomes could only be achieved over a period of time. This resulted in a failure to identify the full range of concerns that were found at Mount Denys. It is also clear that the Registered Manager did not address areas of non-compliance within sufficient timescales.

5.3 Within the DPS a designated Operations Manager took the lead on quality monitoring and compliance with a duty to report and deal with any shortfalls in standards. There has been an

assumption by middle and senior managers in the DPS that the lead Operations Manager and Registered Managers would deal with quality monitoring and compliance and therefore not enough focus has been given within line management arrangements to these core areas of responsibility. This situation has been exacerbated over the past two years by poor attendance by the lead Operations Manager due to periodic ill health. It should be noted that lead Operations Manager was supported in their role by a dedicated management post which was designated to assist in quality monitoring and compliance of DPS services. There is also in place a DPS workforce development group who consider the relevant training and coaching needed by staff to ensure teams had the necessary skills to undertake their care roles and who respond to any practice shortfalls that are identified. Insufficient account was taken of the impact of the lead Operations Manager's sickness absence, particularly given the capacity required to adapt to the new regulatory arrangements. Again, an assumption was made that this responsibility could be managed within the DPS without re-assigning clear roles and tasks in relation to quality monitoring and compliance.

5.4 In June 2011 the DPS began a process of testing the Quality Framework through an internal inspection of Milton Grange. It was noted at that time that the current process did not adequately identify gaps in compliance. Through that work it became clear that there was a need to revise the monitoring systems and this started in July 2011. It was also the intention to internally inspect Mount Denys but this task was pre-empted by the CQC inspection on 18 July 2011.

5.5 As well as considering the shortfalls in internal control it is also important to consider the context in which the Mount Denys service is being delivered. In recent years there has been a steady and incremental increase in the complexity of the needs of people admitted to Mount Denys, both in the level of their mental illness and their challenging behaviour. This development has been accepted within the DPS due to the lack of alternative provision in the independent sector and the requirement to be the "provider of last resort". There has not been, however, a strategic review of the impact of this development and how resources and practices would need to be enhanced to ensure the service remained fit for purpose. This in part reflects the decision that has already been made to close Mount Denys following the development of new services through the Age Well Programme. It is likely therefore not enough attention has been paid to the services current position and the additional staffing capacity it has needed.

5.6 It should also be noted that Mount Denys has taken all referrals, regardless of the level of challenging behaviour. This has sometimes changed dynamics in the service user group and this has increased demands on staffing capacity. Managers have felt that they could not ask for increased resources on an ongoing basis due to the overall local and national pressure on social care budgets and the already relatively high unit costs of Mount Denys. To deal with the challenges in the short term there has been an increase in use of agency staff and this has contributed to CQC concern about the lack of appropriate workforce skill mix to address the needs of the new cohort of service users and the steadily increasing dependency of the long stay residents.

5.7 In relation to the staff group the majority have been working at Mount Denys for many years and have become accustomed to the complex nature of the service users. Over a period of years there has grown an acceptance of violent incidents as part of the nature of the dependent service users they looked after, with this position often being reinforced by the perceptions of relatives and carers who often experience the same challenges. The staff group have, however, demonstrated commitment to addressing the issues raised through the inspection and progress has already been noted by CQC. Similarly, the Registered Manager has shown commitment and dedication to the service users, their carers and staff and is also very committed to the planned improvements. There have been shortfalls in practice but the failings at Mount Denys are systemic and therefore disciplinary action was not appropriate. With coaching and training for managers and supervisors the skills of the team will be improved and this will best serve the sustainability of the service and ensure robust progress continues to be made.

6. Current Position

6.1 Since the inspection there has been ongoing progress in meeting the standards and improving outcomes for service users. An Action Plan has been developed and revised following further feedback from CQC and completion of the initial tasks. (see Appendix 4 – Mount Denys Action Plan). CQC have undertaken two further unannounced inspections on 24 August and 12 September and as a result of progress noted the four warning notices have been withdrawn, although compliance action remains in place. CQC continue to express concern about the sustainability of current improvements

and have requested regular updates on the Action Plan so they can continue to monitor progress. (see Appendix 5 – letters from CQC lifting Enforcement action).

6.2 In regard to the workforce a review of skill mix and capacity has led to an increase to staffing equating to:

- 8 x 30hr Day Care Officer Posts (these will also provide flexibility for cover for sickness and annual leave)
- 2 x 27.5hr Night Care Officer Posts to increase cover seven nights per week
- 2 x Senior Care Officer Posts (total of 60hrs) to provide 24 hour senior cover and management, also to provide additional assistance in emergencies.
- 1 x wte admin to ensure all information is collated for analysis and patterns of incidents are quickly identified and addressed.

6.3 Service user documentation has been simplified and streamlined to facilitate consistency in interventions and recording. A coaching plan is being implemented which includes on-site seminars for staff to improve their skills in recording incidents and information on service user records.

6.4 A Practice Manager (and Registered Mental Health Nurse) is now based at Mount Denys to train, coach and provide leadership for the teams and formulate the strategies for the ongoing development and sustained improvements made at Mount Denys.

6.5 In relation to multi-agency working other professionals, such as therapists and community psychiatric nurses, are involved in the assessment of users and also input into individual support plans. Individual assessments have been reviewed and monthly therapy clinics will take place to assess the mobility of service users and check their walking and other aids. Meetings will also take place every three weeks with the Community Mental Health Team based at St. Anne's Centre to deal with the mental health needs of service users at Mount Denys. Primary Health Teams, as before, are continuing to be engaged in the care of the service users.

7. Summary of Actions to address first three CQC Enforcement Notices:

Regulation 22 - Staffing	Recruitment of 13 permanent staff under way. Training plan and induction agreed to ensure new recruits are suitably skilled and qualified to look after people at Mount Denys
Regulation 11 – Safeguarding people who use services from abuse	Positive behaviour training has been carried out with staff and individual incidents and behaviour monitored. Steps to identify and prevent violence and abuse are agreed, involving mental health teams, Psychiatry, Occupational Therapists, service users, relatives and carers (or their representatives) and the primary health care team.
Regulation 9 - Care and welfare of people who use services	Care plans have been revised, simplified. Assessments have been reviewed. Writing skills seminars for care teams for writing and revising care plans have commenced. Staff capacity has been increased to ensure a holistic person centred approach is delivered.

The response to the fourth enforcement notice is addressed below.

8. Quality Assurance – Summary of Actions to address the fourth Enforcement Notice

8.1 The quality assurance framework has been revised to avoid reliance on individual officers. Monitoring the regulated services will now involve all officers from the Registered Manager to the Head of Service, who will in turn be reporting compliance findings to the ASC Departmental Management Team (DMT). The new DPS Quality Assurance System will be implemented from October and specifies the duties of Registered Managers, Practice Managers, Operations Managers and Heads of Service. Audits of all DPS provision have been undertaken and Action Plans developed to deal with any compliance issues.

8.2 The DPS management team meeting will manage compliance through monthly reviews and DMT will receive quarterly reports.

8.3 To deliver further assurance capacity will be increased within the Quality Monitoring Team which manages quality assurance within the independent sector. This will provide an off-line check to the same standards applied to all commissioned services. The outcome of this monitoring will form part of the quarterly reporting to DMT. The use of peer and service user reviews will also be introduced into monitoring arrangements for the DPS. The arrangements for this will be agreed by DMT in November.

8.4 An initial report on Mount Denys has been made to ASC Scrutiny Committee. The Committee have agreed to convene an additional meeting to consider the full CQC report and undertake a Review of the issues arising from the failure to deliver the required standards at Mount Denys.

9. Strategic Planning

9.1 The Age Well Programme is expected to provide a number of places for people with complex and challenging behaviour, in the next two to five years. The future provision of services for people with dementia, particularly with challenging and complex needs, will be considered as part of the commissioning process. At present there appears to be limited resource for this category of care in the independent sector based on the number of 'failed' placements referred to Mount Denys.

9.2 Greater emphasis is being placed on prevention and Mount Denys is testing in-reach rehabilitation and re-ablement for people admitted for respite care. This is to prevent long-term admissions and maintain the mental capacity of individuals whilst in respite. Future options may include more preventive care.

10. Conclusion

10.1 Action has been taken to address the shortfalls in practice and failures in quality assurance identified through the CQC inspection of Mount Denys. Progress has been made and the Enforcement Notices lifted. Compliance Action is however still in place and CQC will monitor to ensure improvements are sustained.

10.2 Quality assurance systems will be critical in monitoring progress at Mount Denys and ensuring similar issues do not arise again in the future in this or any other DPS provision. The range of monitoring has increased, with independent assurance arrangements being put in place, and roles and duties being more clearly defined.

10.3 The Director of Adult Social Care will provide monthly updates to CQC and the Chief Executive on progress against the Mount Denys Action Plan.

Keith Hinkley
Director of Adult Social Care

Contact Officer:	Shane Heber, Head of Directly Provided Services
Lead Members:	Councillors Elkin and Bentley
Local Members:	Councillor Fawthrop

Appendix 1 **Summary of CQC Enforcements on Mount Denys**

Regulated Activities Regulation 2010	
Failing to comply with Regulation **22**, which states:	In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.
Failing to comply with Regulation **11(1)(a)(b)(2)(a)(b)(3)(a)(b)(c) (d)**of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states:	(1) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of – (a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and (b) responding appropriately to any allegation of abuse. (2) Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control or restraint being - (a) unlawful; or (b) otherwise excessive (3) For the purposes of paragraph (1), "abuse", in relation to a service user, means – (a) sexual abuse; (b) physical or psychological ill-treatment; (c) theft, misuse or misappropriation of money or property; or (d) neglect and acts of omission which cause harm or place at risk of harm
Failing to comply with Regulation **9(1)(a)(b)(i)(ii)(iii)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states:	(1) The Registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of – (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to- (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment,
Failing to comply with Regulation **10**, which states:	(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. (2) For the purposes of paragraph (1), the registered person must— (a) where appropriate, obtain relevant professional advice; (b) have regard to— (i) the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19, (ii) any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity, (iii) the information contained in the records referred to in regulation 20, (iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)), (v) reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations, and (vi) periodic reviews and special reviews and investigations carried out by the Commission in relation to the provision of health or social care, where such reviews or investigations are relevant to the regulated activity carried on by the service provider; (c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to— (i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and (ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies; (d) establish mechanisms for ensuring that— (i) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person (P), and (ii) P is subject to an appropriate obligation to answer for a decision made by P, in relation to the provision of care and treatment for a service user, to the person responsible for supervising or managing P in relation to that decision; and (e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users. (3) The registered person must send to the Commission, when requested to do so, a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (1) are being complied with, together with any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

Appendix 2 Annex A

CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616172

www.cqc.org.uk

BY EMAIL AND RECORDED DELIVERY

East Sussex County Council
County Hall,
St Anne's Crescent
Lewes
East Sussex
BN7 1UE

For the attention of: Becky Shaw – Chief Executive

1st August 2011

Reference number: 1-282352321

Care Quality Commission
The Health and Social Care Act 2008

Dear Madam,

WARNING NOTICE:

This warning notice relates to your registration to carry on the regulated activity: Accommodation for persons who require nursing or personal care at the following location

Mount Denys, 187 the Ridge, Hastings, East Sussex TN34 2AE

We are notifying you that you are failing to comply with relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010).

The Regulated Activities Regulations 2010

You are failing to comply with Regulation 22, which states:

22 In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Why you are failing to comply with this regulation:

1. Following a responsive inspection on 18th July 2011 by Michele Etherton and June

Davies compliance inspectors. It was found that appropriate steps had not been taken to provide sufficient numbers of suitably qualified, skilled and experienced staff to ensure that people living in the home were receiving safe and appropriate, personalised care, treatment and support.

2. Interviews with staff were undertaken during the visit and documentary evidence was supplied by Mount Denys.

3. We were advised that two care staff support ten people on each unit during the day shift supported by a floating care staff member across all three units. A senior staff member is available to each unit in the event of an emergency. On paper this sounds like a sufficient number of staff. However, documentary evidence supplied by Mount Denys in respect of the incidents of physical and verbal violence that have occurred during the period 1st-31st may 2011, indicated an unacceptable level of violence between people living in the home and toward staff. Forty four incidents of physical violence between people living in the home, with an additional twenty-six incidents of physical violence towards staff were recorded. A review of incident reports for June 2011, and July 1st -18th 2011 indicated a similar level of incidents of physical violence.

4. A review of incident reports indicated that staff lack the necessary skills and experience to effectively manage challenging behaviour from people living in the home, are failing to recognise indicators of aggression and de-escalate situations. This demonstrates that there are insufficient numbers of skilled and experienced persons employed for the purposes of carrying on the regulated activity

You are required to become compliant with Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, by 15th August 2011

Please note: you are required to become compliant with the relevant requirement by 15th August 2011. If you fail to do so we may take further action to make sure that you achieve compliance.

We will publish a summary of this warning notice, if you do not agree with this you can make representations to us in writing within 5 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number (above).

If you have any questions about this notice, you can:

a) Contact your local Compliance Manager
b) Contact our National Contact Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely

Marilyn Hansford
Compliance Manager

This notice is served under Section 29 of the Health and Social Care Act 2008.

Date 1st August 2011

Appendix 2 Annex B

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For the attention of Becky Shaw – Chief Executive

1st August 2011

Reference number: 1-282352321

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The Health and Social Care Act 2008

Dear Madam,

WARNING NOTICE:

This warning notice relates to your registration to carry on the regulated activity: Accommodation for persons who require nursing or personal care at the following location

Mount Denys, 187 the Ridge, Hastings, East Sussex TN34 2AE

We are notifying you that you are failing to comply with relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010).

The Regulated Activities Regulations 2010

You are failing to comply with Regulation 11(1)(a)(b)(2)(a)(b) (3)(a)(b)(c) (d)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states

11. (1) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of –

(a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and
(b) responding appropriately to any allegation of abuse.

(2) Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control or restraint being -

(a) unlawful; or
(b) otherwise excessive

(3) For the purposes of paragraph (1), "abuse", in relation to a service user, means –
(a) sexual abuse;
(b) physical or psychological ill-treatment;
(c) theft, misuse or misappropriation of money or property; or
(d) neglect and acts of omission which cause harm or place at risk of harm

Why you are failing to comply with this regulation:

1. Following a responsive inspection on 18th July 2011 by Michele Etherton and June Davies, compliance inspectors, it was found that suitable arrangements had not been made to ensure that people who use the service are safeguarded against the risk of abuse, or that allegations of abuse are responded to appropriately. This is of particular concern as East Sussex County Council has the safeguarding lead for East Sussex.

2. We looked at the incident records for Oak, Willow and Laurel units for May, June, and the period 1st to 18th July 2011. This showed a significant number of physical violence incidents involving people living at the home. Additionally we noted incidents of sexual abuse and also incidents where service users had been found with objects in their mouths e.g. the key to the pad cupboard, leaves, and a lump of soap. Mount Denys supplied a copy of their collated stats for May 2011. This highlighted that there had been approximately forty four incidents of physical violence across all three units between people living in the home during this period. An additional twenty six reported incidents of physical violence were recorded toward staff.

3. Only three of the seventy incidents recorded in May had been reported to CQC as statutory notifications. This demonstrates that allegations of abuse are not responded to appropriately

4. Only four of the seventy incidents recorded in May have been reported through established safeguarding channels in line with local and national policy and guidance. This demonstrates that allegations of abuse are not responded to appropriately

5. When we reviewed incidents, many were recorded as witnessed by staff. We were concerned to note that a number showed a clear escalation from an initial argument to an act of physical violence, and yet staff were not aware of the indicators of possible aggression and did not react in a timely manner to de-escalate situations, and minimize the likelihood of physical violence. In discussion with the registered manager she indicated that some staff may not intervene

because of a fear of being hit themselves. This demonstrates that suitable arrangements are not in place to identify the possibility of abuse and prevent it before it occurs.

6. We expressed concern to the registered manager that there was a culture of violence in the home. The registered manager informed us that there had always been this level of violence in the home, because many of the people in the home had come from other homes that were unable to support their increased challenging behaviour. There was no clear strategy for reducing the level of violence in the home. This demonstrates that suitable arrangements to ensure people are safeguarded against the risk of abuse are not in place

7. Individualised behaviour management guidance to inform staff was minimal where it existed. There was a failure to provide staff with a detailed strategies or guidelines for the consistent and safe management of challenging behaviours. This demonstrates that suitable arrangements are not in place to identify the possibility of abuse and prevent it before it occurs.

9. Physical intervention approvals were in place for some people, but these provided no information about what level of restraint was to be used, when it was to be used, how many staff would be involved, whether this had been approved within a best interest meeting to ensure the rights of the person were protected, or how frequently this was to be reviewed. This demonstrates that suitable arrangements were not in place to protect service users from the risk of excessive or unlawful restraint

You are required to become compliant with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, by 15th August 2011

Please note: you are required to become compliant with the relevant requirement by 15th August 2011. If you fail to do so we may take further action to make sure that you achieve compliance.

We will publish a summary of this warning notice, if you do not agree with this you can make representations to us in writing within 5 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

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Yours sincerely

Marilyn Hansford

Compliance Manager

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The Regulated Activities Regulations 2010

You are failing to comply with Regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states:

9 (1) The Registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of –

(a) the carrying out of an assessment of the needs of the service user; and
(b) the planning and delivery of care and, where appropriate, treatment in such a way as to –

(i) meet the service user's individual needs,
(ii) ensure the welfare and safety of the service user
(iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment,

Why you are failing to comply with this regulation:

1 . Following a visit by Michele Etherton and June Davies, compliance inspectors, it was found that proper steps had not been taken to ensure that the delivery of care ensured people living in the home were receiving safe and appropriate, personalised care, treatment and support.

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2. We noted that there are activity charts for all the units with a range of activities that were offered. However, from records viewed for Oak, Willow and Laurel units, we noted that whilst some of the activities had appropriate records that indicated the same core of people were recorded as participating, there was very little recorded for other people in the home. There were omissions in the frequency of activities offered, with records viewed indicating gaps of between two and five days during the June and July period where no activities took place. Senior staff were unable to explain why this was. It was observed that some residents spend long periods of time sitting in chairs with no engagement opportunities. This demonstrates that proper steps had not been taken to ensure that people living in the home were having their individual needs met.

3. We were concerned to learn that two people who had entered the 'Respite' unit some years ago were still there. There was no evidence that discussions' had taken place with either of the 'people' concerned or their relatives'/representatives' in respect to making the placement permanent

4. We found a lack of pre-admission assessment information to inform the development of care plans, and ensure the needs of the service users could be met within the service. Staff spoken with confirmed that people were often admitted on an emergency basis and the home receive very little information to inform the admission or to make an assessment of its appropriateness. The registered manager advised that in the case of one person admitted into a respite bed some years ago but who was still living at the home; a visit to assess them prior to admission had been undertaken, however, records viewed including archived daily log reports could not evidence this. This demonstrates that proper steps had not been taken to ensure that the people living in the home were receiving safe and appropriate care.

5. We looked at 6 care plans for a randomly selected group of people in the home across the long stay and respite units. There was a degree of personalisation but information was lacking in most areas to inform staff and enable them to provide effective and safe support. We found it difficult to gain a complete picture of how the needs of service users were supported by the home, as information was located in a number of files and locations. This demonstrates that proper steps had not been taken to ensure that people living in the home were receiving safe and appropriate care

6 We were informed by member of staff F that people were involved in and consulted about their support plans and risk assessments. This was not borne out in the care plans viewed where there is little evidence of the degree of involvement of people (or their families) living in the service. This demonstrates that proper steps had not been taken to ensure that people living in the home were having their individual needs met.

8. There was not the expected range of risk assessments in the files viewed. A number of people have had skin tears. There was no evidence that tissue viability assessment had been undertaken to establish the level of risk to people living at the home from pressure sores. We saw no evidence of routine nutritional assessments to highlight those at particular risk from malnourishment or de hydration, and the steps taken to minimize this. In one care plan viewed the person had been assessed as at moderate risk of falling, however, there was no guidance to inform staff about what actions they should take to try to prevent falls occurring. Risk assessments were not completed fully, were not reviewed regularly and were not used appropriately to inform care planning and care delivery. This demonstrates that proper steps had not been taken to ensure that people living in the home were receiving safe and appropriate care.

9. One person D whose file was viewed had recently been admitted to hospital with dehydration. Care plan information for D indicated fluid intake charts were to be recorded. We found one entry for July which recorded fluid input on one date, and recorded output as urine passed in pad. This demonstrates that proper steps had not been taken to ensure that people living in the home were receiving safe and appropriate care

10. We viewed care plans for A,B,C,D,E, and noted bowel charts were in place but, it was unclear why these were in use. Irregular recording on the charts was noted and this could have had an impact on the health and well being of people concerned if regular bowel movements were not maintained.

11. Weight recording was inconsistent in the long stay units. A set of chair scales was available to be used, however, we spoke with the registered manager as to why people's body weights were not regularly recorded. She commented that staff relied more on their own observations of whether people living in the home were losing weight e.g. whether clothes were visibly looser. This demonstrates that proper steps had not been taken to ensure that people living in the home were receiving safe and appropriate care

You are required to become compliant with Regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 15th August 2011

Please note: you are required to become compliant with the relevant requirement by 15th August 2011. If you fail to do so we may take further action to make sure that you achieve compliance.

We will publish a summary of this warning notice, if you do not agree with this you can make representations to us in writing within 5 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number (above).

If you have any questions about this notice, you can:

a) Contact your Compliance Manager
b) Contact our National Contact Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely

Marilyn Hansford
Compliance Manager

This notice is served under Section 29 of the Health and Social Care Act 2008.

Date 1st August 2011

Enc. Key to persons identified in the warning notice

Key to persons identified in the warning notice served on East Sussex County Council re breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

A = service user with the initials V S
B = service user with the initials PS
C = service user with the initials J D
D = service user with the initials S D
E = service user with the initials L J

F = Member of staff with the initials C H

Appendix 2 Annex D

CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616172

www.cqc.org.uk

RECORDED DELIVERY AND EMAIL

East Sussex County Council
County Hall,
St Anne's Crescent
Lewes
East Sussex
BN7 1UE

For the attention of: Becky Shaw – Chief Executive

11th August 2011

Reference number: 1-282352321

Care Quality Commission
The Health and Social Care Act 2008

Dear Ms Shaw,

WARNING NOTICE:

This warning notice relates to your registration to carry on the regulated activity: Accommodation for persons who require nursing or personal care at the following location

Mount Denys, 187 the Ridge, Hastings, East Sussex TN34 2AE

We are notifying you that you are failing to comply with relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010).

The Regulated Activities Regulations 2010

You are failing to comply with Regulation 10, which states:

10 (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to—

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

(2) For the purposes of paragraph (1), the registered person must—

(a) where appropriate, obtain relevant professional advice;

(b) have regard to—

(i) the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19,

(ii) any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity,

(iii) the information contained in the records referred to in regulation 20,

(iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)),

(v) reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations,

and

(vi) periodic reviews and special reviews and investigations carried out by the Commission in relation to the provision of health or social care, where such reviews or investigations are relevant to the regulated activity carried on by the service provider;

(c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—

(i)the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and

(ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies;

(d) establish mechanisms for ensuring that—

(i) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person (P), and

(ii) P is subject to an appropriate obligation to answer for a decision made by P, in relation to the provision of care and treatment for a service user, to the person responsible for supervising or managing P in relation to that decision; and

(e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.

(3) The registered person must send to the Commission, when requested to do so, a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (1) are being complied with, together with any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare..

Why you are failing to comply with this regulation:

1. Following a responsive inspection on 18th July 2011 by Michele Etherton and June Davies, compliance inspectors. It was found that appropriate steps had not been taken to ensure people in the home were protected by the effective operation of systems for quality monitoring of service delivery and effective management of risk.

2. We were informed that service feed back forms were sent out in batches of three at different times of the year, to randomly selected relatives and representatives. However, this was seen to be an inadequate system to elicit quality feedback. We were advised that three were sent out in January 2011 and had been received back or followed up. A further three had been sent out recently but responses had yet to be received. If an effective operating system was in place a proper system to obtain the views expressed by the service users relatives or representatives would be in place to help identify, assess and manage risks relating to the health, welfare and safety of the service users

3. The views of health, social care, and other professionals visiting the home were not sought to inform quality monitoring.

4. Senior staff undertook a range of monthly checks. These included observation of a shift handover to check on content of information, attitude of staff, and staff roles. The last observation of a handover was recorded as completed in June 2011 but not signed. If an effective operating system was in place these observations should have identified risks relating to the health, welfare and safety of the service users in order to assess and manage the same

5. A check was made of the activities that have been provided and this was last recorded as checked in May 2011. This check, however, did not record the level of participation of those people in the home involved and did not record those who were not involved to make assessments about effectiveness and suitability.

6. Meetings were held with people living in the home and minutes of the last meetings held Oct 2010 and Feb 2011 were viewed. These did not demonstrate how the views of service users were taken into account, or informed service development. If an effective operating system was in place a proper system to obtain the views expressed by the service users would be in place to help identify, assess and manage risks relating to the health, welfare and safety of the service users

7. A meals checklist/audit was in place but had not been completed and it was unclear what the home was monitoring

8. A Medicines audit dated 4/7/2011 was not completed.

9. An audit check list was completed by senior staff including care plans, diary sheets, moving and handling, reviews, etc., however, the sheet viewed did not explain what was being checked for, and it was noted that ticks against medication and quality monitoring were absent. If an effective operating system was in place these audits should have identified risks relating to the health, welfare and safety of the service users in order to assess and manage the same

10. Care plans were not specifically individualised and were not supported by or informed by appropriate risk assessments. This was not picked up by the audits undertaken. If an effective operating system was in place this should have identified that the lack of individualised care plans or appropriate risk assessments was a risk relating to the health, welfare and safety of the service users in order that the same could be assessed and managed

11. The manager informed us that quality monitoring sheets were not used to inform the annual development plan for the service and it was unclear if one existed.

12. The provider and the registered manager failed to effectively assess the complex needs of this cohort of residents to ensure the correct levels of staffing, appropriate training and support were in place. If an effective operating system was in place the same should have identified the risks relating to the health, welfare and safety of the service users caused by the lack of proper assessment of the service users needs and the correct staffing levels in order to assess and manage the same

13. The registered person had failed to notify the Commission on a number of occasions of multiple incidents where residents had sustained significant injuries as a result of violent behaviour of other people who use the services. If an effective operating system was in place the same should have resulted in an analysis of these incidents in order to make changes to the treatment or care provided where necessary. It should also have identified that the Commission was not being notified

14. The registered person and other staff have failed to report multiple incidents of physical and verbal abuse, through established Local Authority safeguarding channels for independent investigation. There was failure to aggregate or analyse the range of issues to identify trends or to take appropriate actions. If an effective operating system was in place the same should have resulted in an analysis of these incidents in order to make changes to the treatment or care provided where necessary. It should also have identified that safeguarding referrals were not being made

You are required to become compliant with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, by Friday 9th September 2011

Please note: you are required to become compliant with the relevant requirement by Friday 9th September 2011. If you fail to do so we may take further action to make sure that you achieve compliance.

We will publish a summary of this warning notice, if you do not agree with this you can make representations to us in writing within 5 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number (above).

If you have any questions about this notice, you can:

a) Contact your local inspector or assessor
b) Contact our National Contact Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely

Marilyn Hansford
Compliance Manager

This notice is served under Section 29 of the Health and Social Care Act 2008.

Date 11th August 2011

Appendix 3

Review of compliance

East Sussex County Council Mount Denys	
Region:	South East
Location address:	187 The Ridge Hastings East Sussex TN34 2AE
Type of service:	Care home service without nursing
Date the review was completed:	September 2011
Overview of the service:	Mount Denys is a purpose built home provided by East Sussex County Council for the care of older people with dementia type illness. The home has two long stay units that accommodate ten people each and a respite unit on the first floor that can accommodate eleven people. Bedrooms are single occupancy without ensuite toilet facilities.

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

What we found overall

Mount Denys 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 the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified 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 13 - Staffing
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, checked the provider's records, observed how people were being cared for, looked at records of people who use
services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

One person we spoke with said they had been punched in the face by a man. Another person said they could not remember what they had requested for lunch. Another person commented "staff are on the ball here". One person said they liked the puzzle they had completed.

What we found about the standards we reviewed and how well Mount Denys 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

The dignity of people in the home was not routinely supported. Bedrooms lacked personalisation, and some people lacked adequate bedding. Information was not provided in accessible formats to inform people living in the home's choices and decisions. There was limited evidence that people were being actively consulted about their care and support.

Overall we found Mount Denys was not meeting this essential standard.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

There was a lack of mental capacity assessments to support judgements about consent. There was a lack of evidence that consent is sought from people using the service for care and treatment decisions.

Overall we found Mount Denys was not meeting this essential standard.

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

There was an overall lack of stimulation for people living in the home on a day to day basis. Activities provided did not ensure that all people on every day have some degree of stimulation tailored to their specific needs. Care plans do not provide enough information to inform staff about how to work with and support people effectively and were not supported by or informed by appropriate risk assessments.

Overall we found that Mount Denys was not meeting this essential standard

Outcome 05: Food and drink should meet people's individual dietary needs

People in the home were not provided with accessible information about menus and choice was limited. The specific dietary needs of people in the home were not always well supported. People do not have access to drinks outside of normal meal times and tea breaks and were at risk of not being properly hydrated. Body weights were inconsistently recorded.

Overall we found Mount Denys was not meeting this essential standard.

Outcome 06: People should get safe and coordinated care when they move between different services

The service could not evidence the routine involvement of other health and social care professionals in respect of strategies for working with people in the home.

Overall we found Mount Denys was not meeting this essential standard.

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

There was an established culture of physical and verbal violence in the home between residents and by residents on staff, which put both residents and staff at risk of harm. There was an absence of multi disciplinary input or agreed strategies for managing behaviour. There were inadequate safeguards in place to protect people from harm. Staff lacked the competencies necessary to manage incidents of behaviour effectively and intervene sooner to minimise harm.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection
Staff and people in the home could be exposed to infection because appropriate systems were not in place to protect them.

Overall we found that Mount Denys was not meeting this essential standard.
Outcome 09: People should be given the medicines they need when they need them, and in a safe way
People are not having their medication needs reviewed by a specialist in line with their complex needs.

Overall we found that Mount Denys was not meeting this essential standard

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare
The general environment was stark, and unstimulating. People's activity routine had been disrupted owing to improvement works. People were not provided with necessary support to use call bells effectively. People were at risk of trips and falls through only part removal of carpeting.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
There were inadequate staffing levels with the appropriate knowledge, experience and skills to deliver quality and consistent care and keep residents safe from harm.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
There was a programme of training in place for staff but not all staffing had completed their mandatory training. There was no evidence to indicate that staff competencies in regard to understanding the needs of people with dementia and managing behaviour effectively were routinely assessed and people in the home could be exposed to unnecessary risk because of this.

Overall we found that Mount Denys was not meeting this essential standard.

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 in the home received inappropriate care and treatment because the quality

assurance process was not sufficiently robust to identify problems, and risk was not appropriately managed.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

People were at risk from omissions in recording that could impact on the delivery of care, treatment and support.

Overall we found that Mount Denys was not meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

We have taken enforcement action against East Sussex County Council.

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. Any regulatory decision that CQC takes 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 review 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 1:
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
Due to issues of varying mental capacity people we spoke with were unable to comment specifically about this.

Other evidence
Although generally people we met were well groomed and their clothing clean and appropriate, we did, however observe two men who had uncombed hair and were unshaven. We were advised this was through personal choice.

At the start of our visit we were shown around the two ground floor units 'Oak' and 'Willow'. In 'Oak' unit we found all the bedroom doors were locked and the people in those rooms had no access to them. In the first bedroom we visited we noted that the person in that room did not have a duvet only a duvet cover on the bed. When this was queried with the deputy manager, we were advised that the person in that room became too hot at night and preferred a lighter cover. However, we found a similar lack of duvets in a further four bedrooms we randomly checked on this unit. No clear explanation was given for this lack of bedding for the people in those

rooms.

A review of care plans highlighted no specific reference or agreement to the provision of lighter bed coverings, or that this was an individual choice or that other people had been involved in that decision. An alternative provision of a lighter tog duvet to accommodate those who prefer this was not available.

We also observed in Oak unit that the majority of bedrooms lacked personalisation. One room that was personalised with soft toys belonging to the person in that room. The room felt cold however, a duvet and an additional blanket were seen to be in place.

None of the rooms viewed had a television or radio or other means of stimulation, although we were advised that this was not representative of all the bedrooms in the long term units. When we asked about the absence of televisions and radios in those rooms viewed, we were advised this was because people might break, remove or hurt themselves with these objects. It was not apparent from our discussion with the deputy manager that other means of providing these facilities safely in bedrooms had been considered for the benefit of the people using the rooms.

Similarly, we noted an absence of personal possessions i.e. photos in the long stay units. We were informed that people were likely to tear these up or pull glass framed pictures off the walls and break them endangering themselves and others. When we asked why alternative measures had not been implemented to aid personalisation of bedrooms whilst protecting photos etc we were advised this was an area for development that was currently under discussion.

In another unit we noted that two bedroom doors were wide open. We observed one person in their bed, in another room we saw a person was asleep in an arm chair still dressed in pyjamas at 11:30 am. A review of care plans indicated that some people had requested that their bedroom doors to be left ajar when they were in their rooms; it was unclear however, whether these should be fully open, thereby impacting on their privacy and dignity.

We observed staff talking to people in Oak, Willow and Laurel Units in a kindly and professional manner.

We observed a number of people who were wandering corridors and moving between 'Oak' and 'Willow' units. We noted very little spontaneous interaction occurring between staff and people in the home unless it was attached to a task. We did however observe
one staff member sitting and talking with a person in the main lounge, and later the same staff member was observed to take the arm of another person walking and talking with them in the corridor.

There was a smoker's lounge on the ground floor. This had both a television and a radio. Observation of interaction between staff and some people who smoked indicated that the frequency of their smoking was carefully monitored and controlled by staff, and ensured reasonable intervals occurred between each cigarette. We overheard one person ask a carer for a cigarette, they were told by the carer they

would have to wait until the carer had finished another task. Another time a carer was heard to tell a person that they had only just had one and would now have to wait until after lunch, as a distraction they offered the person concerned a drink and this appeared to settle them.

In Willow unit the majority of rooms viewed had duvets on beds, more rooms were personalised with possessions and photographs, and one had both a television and a radio for personal use.

We noted some signage around the building but this was confined to doors to the kitchenette/dining areas and some toilets/bathrooms. Generally there was insufficient accessible signage to aid people in independently finding their way around the building and to their bedrooms.
The deputy manager indicated that previously, bedroom doors had been personalised with pictures that people would be familiar with and that would help them recognise
their own room. These had gradually been torn off by other people in the home and had not been replaced. The deputy was unclear why alternative options had not been pursued since.

A review of menu information highlighted a lack of commitment by the home to promote, respect and support the individual dietary choices of service users. Information was not provided in formats accessible to the people in the home, and that enabled them to make decisions and choices in their daily lives, such as menu information.

Information about the individual needs of some people in regard to eating was openly displayed on whiteboards in kitchenettes where visitors could also view this, and breached the confidentiality of the people concerned.

Our judgement

The dignity of people in the home was not routinely supported. Bedrooms lacked personalisation, and some people lacked adequate bedding. Information was not provided in accessible formats to inform people living in the home's choices and decisions. There was limited evidence that people were being actively consulted about their care and support.

Overall we found Mount Denys was not meeting this essential standard.

Outcome 2:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are major concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
Due to issues of varying mental capacity people we spoke with were unable to comment specifically about this.

Other evidence
We viewed 6 Care Plans, none of these had consents to care signed, although there was a page at the beginning of the plan of care specifically for this purpose. There was no evidence of family involvement in the care plans viewed, however, one visitor we met stated that they had been fully consulted about their relative's care.

There was an absence of mental capacity assessments to support decisions taken in respect of people's care and treatment.

One file we viewed indicated the person concerned had not been formally reviewed for more than two years, and had initially been admitted into a respite bed. We found there
was a lack of clarity within records as to when this placement had been made permanent.

A recent review indicated the person concerned was able to express their views and feelings, but, also reported they had not been involved in their review or consulted 'for the reasons detailed'. We were unable to establish what these 'reasons' were from the documentation viewed.

Our judgement
There was a lack of mental capacity assessments to support judgements about consent. There was a lack of evidence that consent is sought from people using the service for care and treatment decisions.

Overall we found Mount Denys was not meeting this essential standard.

Outcome 4:
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
The majority or people we spoke with were unable to comment specifically about their care due to issues of mental capacity. However, one person said they liked the puzzle they had completed with staff support.

We spoke with several relatives who commented positively about their experiences of the home and the care delivered to their respective relatives. One person stated they were "very satisfied with the care their relative received", they also reported that staff communicated well about any changes that had occurred; they thought there were a lot of activities for people in the home.

Other evidence

The home has capacity to accommodate thirty one people. Two long stay units 'Willow' and 'Oak' had ten beds in each unit. A further eleven people could be accommodated within the first floor respite unit 'Laurel'. A bed in the respite unit had now been set aside for rehabilitation.

Touring of the home highlighted an overall lack of stimulation for people in the home either visually in the environment or in the level of group or one to one activities offered. Limited attempts had been made to provide environmental stimulation by

the addition of mobiles; these had been hung from skylights.

Some people were observed wandering freely in corridors and communal spaces across both Oak and Laurel units. Other people were observed to spend lengthy periods on their own in chairs around the units with no stimulation or engagement by staff. In the main lounge a large wall mounted television was on at one end of the room, but nobody was watching it.

In the main lounge we observed an agency staff member who we were advised had been brought in specifically to do activities that day. We observed them throwing a ball into a person's lap. During this there was very little interaction observed between the staff member and the person receiving the ball. A number of other people were sitting in the lounge but we observed no attempts to either engage with them or involve them in this activity.

We were informed that activities happen regularly. We looked at activities records for the three units. Activities noted were appropriate but records indicated that there was a small core of the same people attending each time. The records provided no information that activities were happening for the other people in the home on a regular basis. We noted some gaps in the frequency of activities offered, with records viewed indicating gaps of two and five days during the June and July period. Senior staff were unable to explain these omissions but suggested one cause of disruption being the recent redecoration of the main lounge, when it would seem alternative arrangements
had not been made to accommodate activities elsewhere in the home.

We observed two staff in the main lounge sitting with three people, the staff told us they were from an agency and were familiar with the home having worked at the home quite often. One staff member was seen to encourage a person to complete a puzzle and provided some encouragement and support to achieve this. The staff member indicated there were lots of other puzzles to choose from if they wanted but this was a particular favourite of the person who was supported.

Another agency staff member was observed sitting next to a person who was flicking through a news paper reciting the headlines, we observed little interaction between the staff member and the person with no attempt to engage the person in conversation about what they saw in the paper.

However, both agency staff demonstrated familiarity and understanding of the needs of
the people they were supporting including their nutritional requirements. One agency staff member reported that they had learned about people they were supporting from reading their care plans.

Other than the main lounge and the smoking lounge the majority of people in the home did not have access to their own television of radio to enable them to make personal choices about what they watched or listened to.

Call bells had been replaced since the last inspection; these did not have leads and could prevent service users calling for staff attention.

We were concerned that documentation viewed for one person in the respite unit, was not clear about how their respite status changed to long term and who was involved in making that decision, particularly as review information indicated the person concerned had some degree of capacity and could express views and opinions.

We found a lack of pre-admission assessment information to inform the development of care plans, and ensure the needs of the service users could be met within the service. Absence of this information in most cases was supported in conversation with senior staff who confirmed that people were often admitted on an emergency basis and the home often received very little information.

Staff told us that they tended to receive a good level of information about those people who transferred from other homes, but people coming from hospital were sometimes admitted with a brief discharge letter. We looked at information supplied for one person admitted into the respite unit from hospital and noted that the care plan provided made no reference to behaviour exhibited by the person. There was also no evidence of pre-assessment by the home prior to discharge from hospital to the home.

In another case viewed we were advised that the manager had visited to assess the person prior to admission, but records viewed including archived daily log reports could not evidence this.

We viewed 6 randomly selected care plans for people in the home across all three units. We found that care plans contained some personalisation but information was lacking in most areas to inform staff and enable them to provide effective support. We found it difficult to gain a complete picture of the delivery of care to people in the home as information was located in a number of files and locations.

Given that many of the incidents of aggression towards staff requiring some form of physical intervention occur during delivery of personal care; we were concerned to find that information about people's individual personal care routines was minimal. Information viewed failed to reflect what worked well with individuals in order to inform a detailed routine for staff to follow consistently.

In discussion, a newer staff member reported that care plans were completed by senior staff and updated by seniors. Care staff could also make changes as appropriate if they had discussed this with senior staff first.

There was some confusion among staff about the key worker system. However, one staff member told us they were key worker for two people, their role included responsibility for personal shopping, organisation of reviews and liaison with all relevant parties who needed to attend. The same staff member advised us that reviews happened every six months and that people in the home were invited to attend their reviews but often removed themselves during the course of the meeting. They reported that people in the home were involved in and consulted about their support plans and risk assessments, but, we found this was not evidenced in the care plans viewed.

Risk assessments were not always appropriately completed reflective of the needs

of this cohort of residents. Incident records noted a number of people had received skin tears and some people were observed to have recent injuries, some of these people were observed to spend lengthy periods of time sitting in chairs in inactivity.

There were no tissue viability assessments completed to establish the level of risk for individual service users. We saw no evidence of routine nutritional assessments to highlight those at particular risk from malnourishment or dehydration and the steps that may need to be taken to minimise this.

One person whose file was viewed had been admitted recently to hospital with dehydration. Care plan information indicated fluid intake charts were to be recorded. However, we found only one entry for July which recorded fluid input on one date, and recorded output as 'urine passed in pad'.

In one care plan viewed the person had been assessed as at moderate risk of falling however there was no guidance to inform staff as to what actions they should take to try to prevent falls occurring.

In spite of the large numbers of injuries sustained by people in the home from falls, and as the result of violent incidents with other people living in the home, we found only one body map in one file viewed. This recorded a number of injuries for the person concerned none of which were dated and could not be tracked to a specific recorded incident.

The risk assessment completed for each person by the home in regard to emergency evacuation was a generic form. This took no account of the individual behavioural needs of each person, and how this might significantly impact on their ability to evacuate quickly and safely.

In a number of plans viewed physical intervention approvals were in place with some evidence of review. However there was no detail as to what level of physical intervention was approved to be used. Individualised guidance around behaviour management was found to be minimal. There was no evidence that guidance had been developed as a result of the input of other external professionals to ensure best practice.

The majority of people whose plans were viewed experienced some degree of incontinence. Records viewed did not make clear how this was to be managed, e.g. whether a toileting programme was in place and what this consisted of, or how often individuals pads were to be changed. We found that bowel charts were not completed routinely although sheets were in place.

Weight recording was inconsistent in the long stay units. Chair scales were available to be used, but gaps of nearly two months were noted on files viewed. In response to a query about frequency of weight monitoring the registered manager reported that staff rely more on their own observations of whether people were losing weight; e.g. whether clothes were becoming loose.

Our judgement

There was an overall lack of stimulation for people living in the home on a day to

day basis. Activities provided did not ensure that all people on every day have some degree of stimulation tailored to their specific needs.
Care plans do not provide enough information to inform staff about how to work with and support people effectively and were not supported by or informed by appropriate risk assessments.

Overall we found that Mount Denys was not meeting this essential standard

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are major concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The majority or people we spoke with were unable to comment specifically about their care due to issues of mental capacity. However residents spoken to were unable to recall what they had chosen from the menu.

Other evidence

We looked at menus which were in small print and in a written format. Staff told us that service users selected their meal from the menu the previous day using the written menu. In discussion, staff confirmed that the majority of people in the home were unable to read the menu or recall what they had chosen. This was confirmed when we spoke to service users.

We noted that menus viewed did not cater appropriately for vegetarians. At lunch time we observed that one person who was vegetarian received a meal consisting of mashed potato and grated cheese only.

Dining tables in kitchenettes and in the main lounge area were not laid for lunch with tablecloths, cutlery etc.
Staff demonstrated some awareness of people's needs in regard to eating and drinking.
We observed one person who had been given a teaspoon to eat their food because they were likely to eat big lumps of food otherwise. We observed staff ask service

users if it would be ok to place a bib around them at lunchtime.

Some people were observed to have soft diets. There was evidence that external support had been requested for a person at risk of choking through a referral to a specialist team.

We observed that some people had their meals cut up for them and staff were heard and seen offering encouragement to those people who needed it.

We noted some people attempting to leave the table quite early in the meal. These people were encouraged to remain by staff. When we asked a staff member whether people in the home were provided with finger foods to ensure they eat a good diet, we were advised that they receive sandwiches. A review of the menu, however, indicated that sandwiches were usually provided as the tea time option for most people in the home, and not as an additional finger food.

On the day we visited there were two meal options although we were advised by staff that people had been asked to select what they wanted to eat the previous day. Given the limited powers of recollection for most residents this would be inappropriate. Staff said that service users could not have something different from what they had selected previously. It was implied that the kitchen would be unable to cope with a more flexible arrangement.

Bowls of fruit were noted in the kitchenette/dining room but this was kept locked outside of meal times so people in the home would not be able to gain access to this.

Jugs of water or the means to have a drink in a non spill beaker etc was not provided to people in their rooms. We observed people being given drinks at lunchtime, but not all were asked for their preferred choice of drink.

Weight recording was inconsistent in the long stay units. Staff stated that they relied on their own observations of whether people were losing weight; e.g. whether clothes were becoming loose.

Our judgement
People in the home were not provided with accessible information about menus and choice was limited. The specific dietary needs of people in the home were not always well supported. People do not have access to drinks outside of normal meal times and tea breaks and were at risk of not being properly hydrated. Body weights were inconsistently recorded.

Overall we found Mount Denys was not meeting this essential standard.

Outcome 6:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

There are major concerns with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
The majority or people we spoke with were unable to comment specifically about their care due to issues of mental capacity.

Other evidence
Although this standard was not fully inspected, it became clear when we reviewed care plan documentation that their was an absence of involvement from other key health professionals in particular in regard to psychiatrist, psychology, Community Psychiatric Nurse involvement in the development of strategies for managing behaviour, and restraint.

Our judgement
The service could not evidence the routine involvement of other health and social care professionals in respect of strategies for working with people in the home.

Overall we found Mount Denys was not meeting this essential standard.

Outcome 7:
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
One person told us that they had been punched in the face by a man, when we commented about this they said "oh it will happen again it always does"

Other evidence

We spoke with two of the permanent staff team and also two agency staff. All said they received regular safeguarding training.

A newer staff member reported that they had only received safeguarding vulnerable adults training in a previous job.

A longer term staff member told us that they had safeguarding training every year and that this was provided as on line training. The staff member demonstrated an awareness of recent changes to the East Sussex safeguarding protocols and had indicated that the changes would be included in the new on line training. The staff member reported that when an incident occurred, the manager was informed and an incident form completed. The staff member was unclear if incidents were reported through established safeguarding channels.

Examination of the training matrix and subsequent information supplied by the home indicated that within the past two years 75% of staff had received on line safeguarding training, 33% had attended workshops and 50% had their competencies in this area assessed. Records showed three staff who had not received any safeguarding training in the last two years.

In discussion staff demonstrated an awareness of types of abuse and their responsibilities for reporting. However a review of incidents within the home indicated though staff were actively reporting incidents to their manager, these were not all reported appropriately as safeguarding concerns.

We looked at the incident books for all three units for May, June & July and also the home's own collated statistics for the period of May 2011. These indicated an unacceptably high level of physical violence incidents between people in the home and also towards staff, with 44 incidents of physical violence between people across all units in May 2011, and 26 reported physical violence incidents towards staff. Whilst some of these incidents have been reported through the safeguarding process the majority had not, and have also not been made known to CQC through statutory notifications. This evidence demonstrated a culture of physical and verbal violence between residents and also by residents on staff.

We reviewed a number of recorded incidents and found that many were witnessed by staff, and showed a clearly reported escalation in violence from an initial dispute to an act of physical violence. Staff failed to recognise indicators of escalation or provide timely intervention to de-escalate situations, and minimise the possibility of physical aggression. In discussion the manager indicated that staff may not intervene for fear of being hit themselves.
Other incidents we viewed including those where people were found with objects in their mouth, were at risk from other types of abuse or had suffered un-witnessed injuries indicated an overall lack of monitoring and supervision by staff placing people at risk of harm and abuse.

When we raised concerns about the level of violent incidents between people in the home and towards staff, the registered manager reported that this had always been the
case. She reported that the level of incidents was due to the mix of people many of whom were high dependency, and had been placed in the service following failure of other care arrangements.

Physical intervention approvals provided no detail as to what level of restraint was to be used. Or how restraint was to be undertaken and by how many staff. There was no indication of whether best interest meetings had been held, who had been involved, and whether the effectiveness of restraint strategies was being monitored or the frequency of review.

A review of care plans indicated some minimal guidance for staff to manage individual service user's challenging behaviour however this was insufficiently detailed to ensure staff provided support and management in a consistent manner.

We have raised a safeguarding alert encompassing all the people in the home who we believe to be at risk.

Our judgement
There was an established culture of physical and verbal violence in the home between residents and by residents on staff, which put both residents and staff at risk of harm. There was an absence of multi disciplinary input or agreed strategies for managing behaviour. There were inadequate safeguards in place to protect people from harm.

Staff lacked the competencies necessary to manage incidents of behaviour effectively and intervene sooner to minimise harm.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 8:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

Our judgement

There are major concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
The majority or people we spoke with were unable to comment specifically about their care due to levels of mental capacity.

Other evidence
During our site inspection we visited all communal areas in addition to a number of bedrooms in the company of the deputy manager.

We found bedrooms to be generally clean and tidy, although there was an unpleasant odour in some and some bedroom floors were sticky to walk on.

In one smaller lounge there was an unpleasant odour and this seemed to be coming from a corner of the room where there was a large and stained cloth arm chair. This was reported to the deputy manager.

Carpeting in some areas of the home was badly stained.

We observed rubbish bins in the kitchenenette/dining areas to be full to overflowing. One was without a lid at all. Another was overfull with the lid permanently open. Bin lids that were in place were dirty.

We spoke with a domestic staff member who informed us that each unit had their own housekeeper. That there was no set schedule for cleaning with all the domestic staff taking joint responsibility for cleaning the large communal lounge. Each of the

housekeeping staff were also responsible for cleaning their own unit each day. This included cleaning bath hoists but not mobile hoists or wheelchairs. When we visited bathrooms we observed that although bath hoists were generally clean on top and underneath, the backs of the chair on the hoists were grimy with a layer of dust and dirt.

All staffing had access to supplies of protective clothing and cleaning materials. Cupboards used to store cleaning materials were clearly marked and kept locked. A domestic staff member confirmed the availability of regular training in respect of the management of hazardous substances used in cleaning.

Toilets and basins viewed during a walk around the premises were clean in bedrooms and communal areas, liquid soap and paper hand towels were available in most bathrooms and toilets. On one unit owing to problems of the toilet becoming blocked the provider had been proactive in installing an Air blade hand dryer for people to use.

Laundry facilities were visited on all three units. Each unit had an industrial sized washing machine and tumble dryer. Oak and Laurel units had a laundry/sluice room in addition to a separate room for drying and storing clothes. In all three laundry areas soiled clothing was observed to be separated into red bags before being placed in a sluice cycle of the washing machine.

In Laurel unit there was no separation between the sluice facility and the handling of soiled, clean and dry laundry.

Having a sluice facility in close proximity to where clean clothing was being removed from a washing machine and also for clothing to be dried and hung up in an area where a sluice was in use i.e. Laurel unit, were arrangements that could place residents at risk
from cross infection.

From discussion with staff there was no indication that strict protocols were in place to prevent sluicing and laundry activities occurring at the same time to minimise cross infection.

We observed sluice facilities in the laundries on all three units. There was a lack of clarity amongst the staff spoken with about who was responsible for emptying commodes and where. Staff spoken with had been also unclear if this was undertaken exclusively in the sluice areas.

From a review of care plan information we were aware that one person in the home had a Methycillen Resistant Staphylococcus Aureous (MRSA) infection. Observation of the person concerned highlighted that their wound was seeping blood stained fluid through a loose bandage which they were seen to be rubbing on the arms of chairs and on tables. We were concerned that not enough was being done to protect other service users with observed minor injuries from the risk of MRSA.

When we spoke with the domestic staff there was no indication that cleaning routines were adjusted to take account of infections like MRSA to minimise the risk to other people in the home, visitors and staff.

Although 46% of staff received first aid training in 2010/2011 and 97% of staff had received infection control training between 2008/2011, there was evidence that such training is not consistently integrated into practice.

Our judgement
Staff and people in the home could be exposed to infection because appropriate systems were not in place to protect them.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
The majority or people we spoke with were unable to comment specifically about their
care due to levels of mental capacity.

Other evidence
The outcome was not fully assessed. However on interview staff stated that the residents were not medicated to assist in managing their mental health conditions, symptomatology or challenging behaviours. It has been noted under outcome 6 that residents were not given ready access to appropriate health care specialists or to multi disciplinary review. This also meant that their medication needs were not reviewed with
the degree of specialism that their complex needs may require.

Our judgement
People are not having their medication needs reviewed by a specialist in line with their
complex needs.

Overall we found that Mount Denys was not meeting this essential standard

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
The majority or people we spoke with were unable to comment specifically about their care due to issues of mental capacity.

Other evidence
We visited Oak, Willow and Laurel unit. Overall we found that the main décor and fabric of the building was well worn in places and in need of upgrading with paint chips, torn paper and a generally worn appearance.

Communal and bedroom spaces in Oak and Laurel Units were mainly stark in appearance and bedrooms specifically lacked personalisation, These units failed to provide a stimulating or homely environment for the people living there.

In discussion the deputy manager indicated the home was in the middle of redecoration and refurbishment programme. There was evidence of some new redecoration within the main lounge, and staff were heard commenting on the bright colours which had been chosen specifically with the needs of people with dementia in mind. Some new equipment had been ordered to replace hoists and slings.

Carpet tiles were missing from the edges of the main lounge entrance. This could have caused a tripping hazard.

New wood effect non slip type vinyl had been installed in corridors, sky lights had

been replaced, and new ones provided better lighting to corridors and gave a bright airy feel.

The large lounge which had previously been separated by furnishings into smaller areas was at the time of our visit undergoing refurbishment; chairs were around the walls leaving a large unused space in the middle.

A system that used infra red beams had been installed to give staff warning of when a service user had got out of bed or out of their room at night.

We found that a smoker's lounge used by only two people in the home, provided a much more personalised and homelier environment with both a television and a radio for use of service users and also a range of ornaments.

On Laurel unit we found a small communal lounge was also personalised with large print books. A lounge dining area on Laurel appeared over crowded with furniture but provided a more homely environment.

We noted radiator covers in communal spaces and those bedrooms visited. Window restrictors were also seen to be in place.

In some bedrooms visited we noted that beds were away from the wall and could result in a service user falling down the side of the bed against the wall and away from a call bell.

Our judgement
The general environment was stark, and unstimulating. People's activity routine had been disrupted owing to improvement works. People were not provided with necessary support to use call bells effectively. People were at risk of trips and falls through only part removal of carpeting.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 13:
Staffing

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 sufficient numbers of appropriate staff.

What we found

Our judgement

There are major concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
The majority or people we spoke with were unable to comment specifically about staff support due to issues of mental capacity. However, one person commented "staff are on the ball". Another said in regard to a staff member "she's a lovely girl".

Other evidence
We were advised by senior staff that currently all three units were staffed during the day with two care staff in each unit. A floating care staff member was also available to provide support between all three units.

A senior care staff member for each unit was available on the day shift for each unit, but, did not work on the floor unless called there as a result of the emergency alarm being pressed.

On the day we visited agency staff were being used to support these staffing levels due to sickness and holidays. Agency staff spoken with reported that they regularly worked at the home.

Given that many of the people within the home required the support of two staff in respect of any personal care giving, it would not have been possible for existing staffing levels to have effectively and safely delivered personal care to people in the home whilst also maintaining the ongoing safety of other people in the home. This

was evidenced clearly by the unacceptably high number of physically and verbally violent incidents occurring daily in the home. Staffing levels were inadequate to meet the complex needs of the residents in each of the three units.

The cohort of staffing as a whole lacked the knowledge, experience and skills to appropriately support people and keep them safe.

Our judgement
There were inadequate staffing levels with the appropriate knowledge, experience and skills to deliver quality and consistent care and keep residents safe from harm.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 14:
Supporting 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 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
The majority or people we spoke with were unable to comment specifically about their care due to issues of mental capacity.

Other evidence
We spoke with a mix of permanent and agency staff about how their training has been maintained.

One full time staff member said that all their mandatory training was up to date; they had also achieved both a level 2 and level 3 National vocational qualifications. They had also completed a nationally recognised certificate in dementia, and another in palliative care.

We spoke with two agency staff who said they worked regularly at the home and had received all their mandatory training updates through their agency.

A newer staff member reported that they were still on probation but had completed all mandatory training in a previous job.

We looked at the training matrix and it was clear that though there were a range of training opportunities available, many staff had not completed their mandatory training needs.

The training matrix which was difficult to navigate indicated that only approximately

56% of staff had received moving and handling training in the period 2010/2011. Only 26% of staff had completed fire training in the same period although the provider schedule for this was six monthly. 46% of staff received first aid training in 2010/2011. 97% of staff had received infection control training between 2008/2011. 71% of staff had received food hygiene training between 2008/2011. 73% of staff had received training
in the administration of medicines and 43% of staff received safeguarding adults training between 2009 and July 2011.

It was unclear if the remaining percentages of staff were out of date with their mandatory training. It was unclear from the matrix provided how many staff had achieved NVQ level 2.

Given the complex needs of this cohort of residents insufficient specific training was in place around dementia care, the Mental Capacity Act, Deprivation of Liberty, the safe management of challenging behaviours, care planning or risk assessments. The training matrix indicated that only two staff had received dementia care training.

There was some evidence of other work related training for staff.

As stated not all mandatory training needs had been met. In addition there was evidence that not all training received had been consistently integrated into everyday practice as indicated by concerns relating to effective infection control and the appropriate rising of safeguarding concerns.

We saw evidence that staff were in receipt of regular supervision from senior members of staff.

Senior members of staff receive supervision from the registered Manager. However, such supervision had failed to identify, or act on issues of repeated violence experienced by staff from residents.

All staff received an annual appraisal but development plans failed to identify and address training needs appropriately.

All new staff underwent an introductory induction for three days when they commenced work at the home. The worked under supervision until they had become familiar with and to the people in the home.

Our judgement
There was a programme of training in place for staff but not all staffing had completed their mandatory training. There was no evidence to indicate that staff competencies in regard to understanding the needs of people with dementia and managing behaviour effectively were routinely assessed and people in the home could be exposed to unnecessary risk because of this.

Overall we found that Mount Denys was not meeting this essential standard.

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
The majority or people we spoke with were unable to comment specifically about their care due to issues of mental capacity.

Other evidence
We looked at how quality monitoring of the service was undertaken.

We were informed that service feed back forms were sent out in batches of three at different times of the year to randomly selected relatives and representatives. However, this was seen to be an inadequate system to elicit quality feedback. We were advised that three were sent out in January 2011 and had been received back or followed up. A further three had been sent out recently but responses had yet to be received.

The views of Health, social care, and other professionals visiting the home were not sought to inform quality monitoring.

Senior staff undertook a range of monthly checks. These included, observation of a shift handover to check on content of information, attitude of staff, and staff roles. The last observation of a handover was recorded as completed in June 2011 but not signed.

A check was made of the activities that have been provided and this was last recorded as checked in May 2011. This check, however, did not record the level of participation of those people in the home involved and did not record those who were not involved to make judgements about effectiveness and suitability.

Meetings were held with people living in the home and minutes of the last meetings held Oct 2010 and Feb 2011 were viewed. These did not demonstrate how the views of service users were taken into account, or informed service development.

A meals checklist/audit was in place but had not been completed and it was unclear what the home was monitoring.

A number of audits were noted including health and safety, first aid boxes, staff supervisions, staff attendance at training, staff sickness levels. However these had limited value since as already stated there were inadequate staffing levels in place with the appropriate skills and experience to deliver safe, quality care consistently. There was a lack of robustness to the supervision delivered to staff. Mandatory training needs were not met for all staff.

A Medicines audit dated 4/7/2011 was not completed.

An audit check list was completed by senior staff including care plans, diary sheets, moving and handling, reviews, etc., However, the sheet viewed did not explain what was being checked for, and it was noted that ticks against medication and quality monitoring were absent. The audit form was last completed on 04/07/2011, but did not lend itself to comments regarding actions taken to address shortfalls.

As stated the care plans were not specifically individualised and were not supported by or informed by appropriate risk assessments. This was not picked up by the audits undertaken.

The manager informed us that quality monitoring sheets were not used to inform the annual development plan for the service and it was unclear if one existed.

The provider and the registered manager failed to effectively assess the complex needs of this cohort of residents to ensure the correct levels of staffing, appropriate training and support were in place.

The registered person had failed to notify the Commission on a number of occasions of multiple incidents where residents have sustained significant injuries as a result of violent behaviour of other people who use the services.

The registered person and other staff have failed to report multiple incidents of physical and verbal abuse through established Local Authority safeguarding channels for independent investigation. There was failure to aggregate or analyse the range of issues to identify trends or to take appropriate actions.

Our judgement
People in the home received inappropriate care and treatment because the quality assurance process was not sufficiently robust to identify problems, and risk was not appropriately managed.

Overall we found that Mount Denys was not meeting this essential standard.

Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
The majority or people we spoke with were unable to comment specifically about their care due to issues of mental capacity.

Other evidence
We were aware that the outcome of a recent safeguarding investigation highlighted concerns at the quality of recording including some omissions in recording. However actions to address the issue had not been taken.

During our visit we noted that the content of information in care plans, risk information, and in guidance to staff to inform their support of people in the home was inadequate. Some omissions in recording were also noted.

Not all relevant information about people living in the home was contained within their care plan e.g. weight charts, visits from health professionals, activities, these were kept collectively in other files and consequently failed to give a full overview of how individuals care, treatment and support needs were being met. We found a disjointed/fragmentary approach to the collation and holding of information

Records were securely held and confidentiality of written information maintained.

Our judgement

People were at risk from omissions in recording that could impact on the delivery of care, treatment and support.

Overall we found that Mount Denys was not meeting this essential standard.

Action we have asked the provider to take
we have asked the provider totake

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (RegulatedActivities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The dignity of people in the home was not routinely supported. Bedrooms lacked personalisation, and some people lacked adequate bedding. Information was not provided in accessible formats to inform people living in the home's choices and decisions. There was limited evidence that people were being actively consulted about their care and support.	
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: There was a lack of mental capacity assessments to support judgements about consent. There was a lack of evidence that	

	consent is sought from people using the service for care and treatment decisions.	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People in the home were not provided with accessible information about menus and choice was limited. The specific dietary needs of people in the home were not always well supported. People do not have access to drinks outside of normal meal times and tea breaks and were at risk of not being properly hydrated. Body weights were inconsistently recorded	
Accommodation for persons who require nursing or personal care	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	How the regulation is not being met: The service could not evidence the routine involvement of other health and social care professionals in respect of strategies for working with people in the home.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: Staff and people in the home could be exposed to infection because	

	appropriate systems were not in place to protect them.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People are not having their medication needs reviewed by a specialist in line with their complex needs.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: The general environment was stark, and unstimulating. People's activity routine had been disrupted owing to improvement works. People were not provided with necessary support to use call bells effectively. People were at risk of trips and falls through only part removal of carpeting.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: There was a programme of training in place for staff but not all staffing had completed their mandatory training. There was no evidence to indicate that staff competencies in regard to understanding the needs of people with dementia and	

	managing behaviour effectively were routinely assessed and people in the home could be exposed to unnecessary risk because of this.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People were at risk from omissions in recording that could impact on the delivery of care, treatment and support.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action being taken			
Warning notice This action is being taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	**Timescale** (if applicable)
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	There was an overall lack of stimulation for people living in the home on a day to day basis. Activities provided did not ensure that all people on every day have some degree of stimulation tailored to their specific needs. Care plans do not provide enough information to inform staff about how to work with and support people effectively and were not supported by or informed by appropriate risk assessments.		15 August 2011

Enforcement action being taken
Warning notice This action is being taken in relation to:

Regulated activity	Regulation or section of the Act	Outcome	Timescale (if applicable)
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	There was an established culture of physical and verbal violence in the home between residents and by residents on staff, which put both residents and staff at risk of harm. There was an absence of multi disciplinary input or agreed strategies for managing behaviour. There were inadequate safeguards in place to protect people from harm. Staff lacked the competencies necessary to manage incidents of behaviour effectively and intervene sooner to minimise harm.		15 August 2011

Enforcement action being taken

Warning notice

This action is being taken in relation to:

Regulated activity	Regulation or section of the Act	Outcome	Timescale (if applicable)
Accommodation for persons who require	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing	

nursing or personal care	**How the regulation or section is not being met:**	**Registered manager:**	**To be met by:**
	There were inadequate staffing levels with the appropriate knowledge, experience and skills to deliver quality and consistent care and keep residents safe from harm.		15 August 2011

Enforcement action being taken

Warning notice

This action is being taken in relation to:

Regulated activity	**Regulation or section of the Act**	**Outcome**	**Timescale** (if applicable)
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People in the home received inappropriate care and treatment because the quality assurance process was not sufficiently robust to identify problems, and risk was not appropriately managed.		29 August 2011

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 Adult 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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Appendix 4

East Sussex County Council Adult Social Care Directly Provided Services

Plan to address Enforcement Action regarding non compliance of Mount Denys Mental Health, following an Inspection by the Care Quality Commission on 18th July 2011

Date of Report: 26 August 2011

East Sussex County Council

eastsussex.gov.uk

Outcome 1

Outcome 1 (Regulation 17) Respecting and involving people who use services	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at 26 August 2011
Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Outcome 1 – 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.	The dignity of people in the home was not routinely supported. Bedrooms lacked personalisation and some people lacked adequate bedding. Information was not provided in accessible formats to inform people living in the home's choices and decisions. There was limited evidence that people were being actively consulted about their care and support	Accessible information to be made available to promote choice and control and involvement wherever possible of service users in their day to day lives. • Information to be available e.g. menus, staff on duty, accessible lists for available snacks/drinks for service users to be placed in units. • Signage to be improved and available on each unit • Personalisation of individual rooms	Individuals will have choice on a daily basis to ensure that their preferences are routinely taken into account. Individuals are given every opportunity to make informed choices about food and drink, and when they would like it make requests. Individuals are able to be as independent as possible moving around the building using the accessible signage. Individuals are able to identify their own rooms have their own identities expressed and respected.	**1/8/11** Teresa Harrison, Practice Manager, Compliance lead/ Lisa Gyalog, Service User Involvement Worker **31/9/11** Shane Heber, Head of Service, Directly Provided Services/Cheryl Bone, Special Projects Manager Lisa Gyalog, Service User Involvement Worker	**COMPLETED** A Consultant with expertise in signage for people in mental health services will be engaged to look at Mount Denys signage in the longer term. Service user involvement worker is engaging with service users, staff and where possible, relatives to ensure improved personalisation of individual rooms

Outcome 1 (Regulation 17) Respecting and involving people who use services	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at 26 August 2011
		Specific choices from Service Users/ representatives in relation to bedding preferences to be detailed in their support plans.	Individuals will have their own choice and preference of bedding ensuring they are at the centre of the support they receive.	**9/9/11** Janice Phillips, Registered Manager	**Work commenced**. As an interim measure summer weight duvets (2 – 4 togs) have been ordered. Currently additional bed sheets have been made available as required.
		Review the practice of locking and leaving "ajar" service user doors to enable service users to maintain their dignity and access their rooms. Service User/ representative choices in relation to both of the above to be detailed on their support plan.	Respect and dignity of individuals will be maintained by staff and other service users	**9/9/11** Janice Phillips, Registered Manager/Sue Reilly RMN, Practice Manager, Mental Health Lead	**Work commenced**
		Communication Lead/ Champion to be identified to link with existing champions within DPS for support.	All individuals will be supported to communicate their views, choices and preferences wherever possible and be involved in decisions made about their care and daily lives	**12/8/11** Lisa Gyalog, Service User Involvement Worker/Janice Phillips, Registered Manager	**COMPLETED**
		Review of the current activity programmes on offer with involvement from all Users and families, using implemented accessible information.	A flexible, responsive activity programme will be available that meets individual needs and choices in relation to their preferences, lifestyle choices and beliefs.	**9/9/11** Lisa Gyalog, Service User Involvement Worker/Janice Phillips, Registered Manager	**Work commenced**

Outcome 1 (Regulation 17) Respecting and involving people who use services	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at 26 August 2011
		Activity Training to be sourced for identified staff.	Individuals will receive the appropriate level of skilled support from staff in relation to their personalised activity programmes.	**30/9/11** Janice Phillips, Registered Manager/ Teresa Harrison, Practice Manager, Compliance lead	**COMPLETED**
		Management to ensure all records relating to service users are held confidentiality, this includes information on individual needs in regard to eating.	Individuals will be protected from abuse and/or potential abuse and their dignity and respect is maintained.	**12/8/11** Janice Phillips, Registered Manager/Sue Reilly RMN, Practice Manager, Mental Health Lead	**COMPLETED**
		Confidential Service User card system to be developed for reference by Cook / serving staff outlining service user preferences & nutritional needs. (Please also see actions relating to Regulation 9)	Individual needs and preferences around meals, drinks and lifestyle choices are known and catered for.	**9/9/11** Janice Phillips, Registered Manager	**Work commenced**
		Accessible information to be made available to promote choice and control and involvement wherever possible of service users in their day to day lives. Information to be available e.g. menus, staff on duty, accessible lists for available snacks/drinks for service users to be placed in units	Individuals have access to information to make informed choices about the meals they would like on a day to day basis. Individuals have access to snacks/ drinks menu to make informed choices about what and when they would like these.	**1/8/11** Teresa Harrison, Practice Manager, Compliance lead/ Lisa Gyalog, Service User Involvement Worker	**COMPLETED**

Outcome 1 (Regulation 17) Respecting and involving people who use services	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at 26 August 2011
Other evidence – Outcome 1	Two men had uncombed hair and were unshaven	Communication needs/ personal care needs/ focussed activity needs – all to have specific guidelines/strategies for each individual.	Individuals have person centred support plan in place agreed with them, or their representative(s) clearly setting out their support needs, choices and preferences and how these are to be met.	**5/8/11** Janice Phillips, Registered Manager/Sue Reilly RMN, Practice Manager, Mental Health Lead	**COMPLETED** - Quality auditing is ongoing.
	None of rooms viewed had a television or radio or any means of stimulation.	Whilst a number of service users already had TVs and radios in their room , further Involvement being undertaken with service users / representatives in reviewing individual's rooms and any potential risks involved with the addition of TV/radio etc. To include looking at fixed items on walls/overhead speakers	All individuals will be supported to communicate their views, choices and preferences wherever possible and be involved in decisions made about their care and daily lives	**30.9.11** and ongoing Janice Phillips, Registered Manager, Debbie Greathead, Deputy Manager, Andrew James, Gail Allam, Pat Boland, Jackie Sellens, Senior Care Officers	**Work commenced**
	Absence of personal possessions in long stay units	Involve service user /representatives in reviewing individuals rooms and any potential risks involved with keeping personal possessions.	All individuals/representatives will be supported to communicate their views, choices and preferences wherever possible and be involved in decisions made about their care and daily lives	**31/10/11** Janice Phillips/Registered Manager for long stay users Ongoing process for new admissions	Information has been gathered from long term residents as to their preferences and work commenced to personalise rooms i.e. painting rooms and doors. Personalised bedding introduced
	Service users wandering corridors and little interaction	Review of the current activity programmes on offer with involvement from all service users and families, using	A flexible, responsive activity programme will be available that meets individual needs, including 1:1 interaction.	**9/9/11** Lisa Gyalog, Service User Involvement Worker, Janice Phillips, Registered Manager	Communication champion Sam Phillips appointed as Communications Champion to develop

Outcome 1 (Regulation 17) Respecting and involving people who use services	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at 26 August 2011
		implemented accessible information. Review of staffing numbers.	Individuals continue to receive support from skilled, trained and competent staff in sufficient numbers		skills to work with staff in dealing with people with dementia and their stimulation **COMPLETED** Skills development ongoing
	Individual needs of people with regard to eating was displayed on white boards	This information will be put on information boards in the manager's office accessed only by staff to maintain confidentiality whilst meeting service user's individual nutritional needs.	Individual nutrition needs/ preferences and lifestyle choices are catered for and provide sufficient choices for individuals whilst meeting their nutritional needs and maintaining a healthy lifestyle.	**30.9.11** Mark Butterworth/Practice Manager/Occupational Therapist	In addition Occupational therapist reviewing eating requirements of individual service users to ensure the correct equipment is available at Mount Denys.

Outcome 2

Outcome 2 (Regulation 18) **Consent to Care and Treatment**	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 **Outcome 2 – Consent to care and treatment** **What the outcome says** This is what people who use services should expect. People who use services: * Where they are able, give valid consent to the examination, care, treatment and support they receive. * Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed. * Can be confident that their human rights are respected and taken into account.	There was a lack of mental capacity assessments to support judgements about consent. There was a lack of evidence that consent is sought from people using the service for care and treatment decisions. Overall we found Mount Denys was not meeting this essential standard .	Following a review of all service users under safeguarding process, Management to ensure a record/log is kept of all the updated capacity assessment decisions, DOLS and best interest decisions to ensure these are reviewed regularly with the relevant ACM/MHT teams and families as appropriate	Where individuals are unable to make informed decisions about an area of their lives, it will be ensured that their best interests are maintained and the appropriate level of support given by staff.	**12/8/11** Janice Phillips, Registered Manager/Sue Reilly RMN, Practice Manager, Mental Health Lead	**COMPLETED**
		The current review process to be reviewed to ensure involvement of service user, relatives/ representatives and professionals and formal recording of discussions and agreements reached to be kept on file.	As individual's circumstances, needs and abilities change the above is reviewed to ensure the individual continues to be at the centre and involved wherever possible in understanding and planning their support.	**30/9/11** Janice Phillips, Registered Manager/Sue Reilly RMN, Practice Manager, Mental Health Lead/Audrey Franks, Operations Manager	**Work commenced**
		Log/spreadsheet to be developed to monitor and evidence regular review activity and levels of involvement for quality monitoring purposes.	Individual circumstances will be clearly detailed and available to monitor and ensure these decisions are reviewed and in place as required.	**30/8/11** Janice Phillips, Registered Manager/Sue Reilly RMN, Practice Manager, Mental Health Lead	**Work commenced**

Outcome 4

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
Enforcement Action **Failing to comply with Regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states:** 9 (1)The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of – (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to – (i) meet the service user' individual	1. Proper steps had not been taken to ensure that the delivery of care ensured people living in the home were receiving safe and appropriate, personalised care, treatment and support	Service/Support Plans - New support profiles/plans to be implemented for all service users. Sue and Janice to go through with the seniors and complete good practice example of a support profile for staff to refer to.	Individuals have person centred support plan in place agreed with them, or their representative(s), clearly setting out their support needs, choices and preferences and how these are to be met. Individuals are supported by staff who are aware of how their needs are met.	**29/7/11** Sue Reilly, RMN, Practice Manager. Mental Health Lead/ Janice Phillips Registered Manager/ Andrew James, Gail Allam, Pat Boland, Jackie Sellens, Senior Care Officers	**COMPLETED. Quality auditing is ongoing**
	5. Six care plans for a randomly selected group of people in the home across the long stay and respite units. There was a degree of personalisation but information was lacking in most areas to inform staff and enable them to provide effective and safe support. We found it difficult to gain a complete picture of how the needs of service users were supported by the home, as information was located in a number of files and locations.	Plans to include: - Specific strategies and guidelines for individual service users for challenging behaviour and vulnerability. - Format to be agreed to include preventative measures, warning signs, triggers, diversion and de-escalation techniques. - Support from Amelia Culshaw (Trainer) to be sourced.	Individual support plans set out guidelines for staff on how to support them positively to reduce the risk of challenging behaviours. Levels of incidents experienced by individuals are reduced	**26/7/11** Teresa Harrison Practice Manager, Compliance lead// Sue Reilly, Practice Manager, RMN, Mental Health Lead/ Janice Phillips, Registered Manager.	A "Positive Behaviour Support Plan" has now been identified and introduced. The form allows information relating to warning signs/triggers, diversion and de-escalation techniques to be recorded. There is also monitoring tool within the form which allows recording of when the strategies/guidelines are used. This will allow for analysis and tracking of the effectiveness of the strategies/guidance in place. **COMPLETED**

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
needs, (ii) ensure the welfare and safety of the service user (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.	**6**. Informed that people were involved in and consulted about their support plans and risk assessments. This was not borne out in the care plans viewed where there is little evidence of the degree of involvement of people (or their families) living in the service.	- Holistic person centred, individualised support plans to include areas where individuals are able to make informed choices. Service User involvement worker to support role out	Individuals have person centred support plan in place agreed with them or their representative(s), clearly setting out their support needs, choices and preferences and how these are to be met. Individuals are supported by staff who are aware of how their needs are met.	**29/7/11** Lisa Gyalog, Service User Involvement Worker/ Teresa Harrison, Practice Manager, Compliance Lead/ Sue Reilly, Practice Manager, RMN, Mental Health Lead.	**COMPLETED**
	8. There was not the expected range of risk assessments in the files viewed. A number of people have had skin tears. There was no evidence that tissue viability assessment had been undertaken to establish the level of risk to people living at the home from pressure sores. We saw no evidence of routine nutritional assessments to highlight those at particular risk from malnourishment or de hydration, and the steps taken to minimize this. In one care plan viewed the person had been assessed as at moderate	Risks to service users to be clearly identified (Initial risk profile) and actions taken to reduce risks clearly detailed on all individual risk assessments. Reviews and updates to be clearly detailed	Individuals or their representative are able to make informed choices around risk taking and are supported to identify control measures to minimise risk. Individuals or their representative(s) are supported to review these risks.	**29/7/11** Janice Phillips, Registered Manager/ Sue Reilly,RMN, Practice Manager, Mental Health Lead	**COMPLETED**
		Detailed evidence of involvement in Individual agreeing to support plan and/or family, professional and/ or other representatives	Individuals or their representative(s) contribute and consent to support plans in the care and support they received. Individuals or their representative(s) will see and agree to information recorded and provided to staff about them.	**30/9/2011** Janice Phillips, Registered Manager/ Sue Reilly, RMN Practice Manager, Mental Health Lead	The new support plans will be agreed with service users and/or their representative. There are some outstanding signatures required but these are being actively sought from service user's representatives/professionals

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	risk of falling, however, there was no guidance to inform staff about what actions they should take to try to prevent falls occurring. Risk assessments were not completed fully, were not reviewed regularly and were not used appropriately to inform care planning and care delivery. This demonstrates that proper steps had not been taken to ensure that people living in the home were receiving safe and appropriate care	Initial risk profiles to be undertaken for all existing service users and reviewed 6 monthly	Individuals or their representatives are able to make informed choices around risk taking and are supported to identify control measures to minimise risk. Individuals are supported to review these risks.	**5/8/11** Janice Phillips, Registered Manager/ Sue Reilly,RMN, Practice Manager, Mental Health Lead	**COMPLETED**
		Any Restrictive Physical Interventions drawn up to be personalised for each individual service user and accompanied by a Supported decision Making process form. Also needs to be noted that RPI action is last resort after trying all guidance/strategies for the individual service user.	Levels of incidents experienced by individuals are reduced. Individuals will receive support from representatives/ professionals to identify and provide a co-ordinated person centred approach to ensure individual needs are met and safeguarded.	**29/7/11** Sue Reilly, RMN Practice Manager, Mental Health lead/Janice Phillips, Registered Manager/ Teresa Harrison, Practice Manger, Compliance lead	A supported decision making process form has been implemented to support the Restrictive Physical Intervention process. The supported decision making process involves key people in the individuals life to agree to the support detailed in the RPI, families and other professionals have been involved in this process. All RPIs have been updated to reflect personalisation and are accompanied by a Supported Decision Making process form. The forms clarify that the RPI is a last resort after trying all other guidance/strategies in the support plan. There are some outstanding signatures required from relatives but these are being actively sought, however conversations continue with user representatives/professionals Only two signatures outstanding. Ongoing process as any new issues arise

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		Communication needs/ personal care needs/ focussed activity needs – all to have specific guidelines/strategies for each individual.	Individuals have person centred support plan in place agreed with them, or their representatives clearly setting out their support needs, choices and preferences and how these are to be met. Individuals are supported by staff who are aware of how their needs are met. Individuals or their representatives are supported to be involved and make choices about their care and support using their preferred methods of communication	**5/8/11** Janice Phillips, Registered Manager/ Sue Reilly, RMN, Practice Manager, Mental health Lead.	**COMPLETED** - Quality auditing is ongoing.
	9. Care plan information for D indicated fluid intake charts were to be recorded. We found one entry for July which recorded fluid input on one date, and recorded output as urine passed in pad. This demonstrates that proper steps had not been taken to ensure that people living in the home were receiving safe and	Also nutritional needs where relevant	Individuals have person centred support plans in place agreed with them ,or their representatives, clearly setting out their support needs, choices and preferences and how these are met	**29/7/11** Janice Phillips, Registered Manager, Sue Reilly, Practice Manager, RMN, Mental Health Lead	Malnutrition Universal Screening Tool. **COMPLETED**

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	appropriate care				
	10. Irregular recording on bowel charts was noted and this could have had an impact on the health and well being of people concerned if regular bowel movements were not maintained.	Agreed updates on service plans/ risk assessments/ guidelines to be handwritten until such time as can be typed. Amendments must be dated and signed.	Individual records are kept up to date and reflect the current level of support required to meet individual needs.	**5/8/11** Janice Phillips, Registered Manager, Sue Reilly, Practice Manager, RMN, Mental Health Lead	**COMPLETED** & ongoing
	11. Weight recording was inconsistent in the long stay units. This demonstrates that proper steps had not been taken to ensure that people living in the home were receiving safe and appropriate care	Agreed updates on service plans/ risk assessments/ guidelines to be handwritten until such time as can be typed. Amendments must be dated and signed.	Individual records are kept up to date and reflect the current level of support required to meet individual needs.	**5/8/11** Janice Phillips, Registered Manager, Sue Reilly, Practice Manager, RMN, Mental health lead	**COMPLETED & ongoing**
	2.Lack of individual activities and frequency demonstrated that proper steps had not been taken to ensure that people living in the home were having their individual needs met .	Activity log for each individual service user alongside specific guidelines	Individuals are supported to be involved and make choices about the activities on offer to provide cognitive and social stimulation. A personalised activity programme agreed with each individual or their representatives that reflects their abilities and preferences.	**5/8/11** Janice Phillips, Registered Manager, Sue Reilly, Practice Manager, RMN, Mental Health Lead	**COMPLETED** Quality auditing is ongoing
		Consent information to be completed for all service users.	Individuals or their representatives contribute and consent to support plans in the care and support they	**30/9/11** Janice Phillips, Registered Manager, Sue Reilly, Practice Manager, RMN, Mental	Consent information has been completed for all service users and signed by those service users that are able. Outstanding signatures are being actively sought from

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
			received. Service users or their representative(s) can expect to have their support plans explained to them, and have the opportunity to discuss these.	Health Lead. Dr Stephen, Psychiatrist, Community Mental Health Team/Dr Mutiboko, Consultant Psychiatrist, Community Mental Health Team, Paul Deigan, lead Mental Health Nurse, Community Mental Health Team, Kate Meyer, Senior Practitioner, Community Mental Health Team, Pete Forman, Practice Manager, Community Mental Health Team	representatives/professionals
		Capacity assessments & Best interest decisions to be clearly detailed and reviewed.	Individuals will receive support from multi agency professionals to identify and provide co-ordinated person centred approach to ensure individual needs are met and safeguarded	As above	**COMPLETED**
		Malnutrition Universal Screening Tool to be included alongside each service users support plan.	Individuals will have their support needs met with regard to nutrition and hydration through regular assessment, and the seeking of guidance/professional support as required	**29/7/11** Janice Phillips, Registered Manager, Sue Reilly, Practice Manager, RMN, Mental Health Lead	**COMPLETED**

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		Waterlow to be included alongside support plan and related guidelines, including risks re: pressure sores, skin tears etc	Staffs are able to identify any risks relating to pressure sores and skin tears, and seek specific guidance, professional support or equipment that is required to keep individuals' skin healthy.	**30/10/2011** Janice Phillips, Registered Manager, Sue Reilly, Practice Manager, RMN, Mental Health Lead, Sharon Hulme, Practice Manager (RGN) Joint Health and Social Care Manager.	Sharon Hulme delivered training on Waterlow scoring week beginning 10/8/11. Further training is planned for September and October and information pack on Waterlow is being developed.
		PEEPS (Personal Emergency Evacuation Plans) to clearly detailed service user and individualised support needed in an emergency, day & night	Service users are kept safe in the event of any emergency i.e. fire. Staff will have an awareness and understanding of the individual needs of each service user in order for this to be achieved safely.	**16/9/11** Janice Phillips, Registered Manager, Mount Denys/ Sue Reilly,RMN, Practice Manager, Mental Health Lead/ Senior Care Officers	The current PEEPS is being revised to include individual behaviours in various circumstances
		Accessible information to be made available to promote choice and control and involvement wherever possible of service users in their day to day lives. (Service User Involvement Worker) • Information to be available e.g. menus, staff on duty, accessible lists for available snacks/drinks for service	Individuals have access to information to make informed choices about the meals they would like on a day to day basis. Individuals have access to snacks/ drinks menu to make informed choices about what and when they would like these. Individuals are able to be independent in accessing different areas of the building at Mount Denys and to	**1/8/11** Teresa Harrison, Practice Manager, Compliance lead/ Lisa Gyalog, Service User Involvement Worker **30/9/11** Shane Heber, Head of Service, Directly Provided Services/Cheryl Bone, Special Projects Manager	**COMPLETED** A Consultant with expertise in signage for people in mental health services will be approached to look at Mount Denys signage in the longer term. Service user involvement worker is engaging with service users, staff and where possible, relatives to ensure improved personalisation of individual rooms

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		users to be placed in units. • Signage to be improved and available on each unit • Personalisation of individual rooms	find their way around using accessible signage. Individuals have choice and control over personalising their rooms. Individuals are able to identify their own rooms and have their own identities expressed and respected.	**30/9/11** Lisa Gyalog, Service User Involvement Worker	**Work commenced**
		Welcome pack to be reviewed updated – to include other information including SAR and How to make a complaint – (Service user involvement worker to action) All service users to have access to information contained in welcome pack.	Individuals or their representative(s) have information to make informed choices about the service and the support provided at Mount Denys.	**31/8/11** Teresa Harrison, Practice Manager, Compliance Lead/ Lisa Gyalog, Service User Involvement Worker	**COMPLETED**

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	4. Found a lack of pre-admission assessment information to inform the development of care plans, and ensure the needs of the service users could be met within the service. People were often admitted on an emergency basis and the home receive very little information to inform the admission or to make an assessment of its appropriateness. This demonstrates that proper steps had not been taken to ensure that the people living in the home were receiving safe and appropriate care.	Implement Pre admission summary/assessment, including initial risk profile - record detailing pre admission information to be more comprehensive. Also guidance on pre admission information to be put in place for emergency admissions where home visits may not be possible. (Refer to admission summary and initial risk assessment/profile processes already in place in other DPS services). Risks to existing service users/ staff must be detailed and inform decision around accepting/ declining referral.	Individuals and their representatives are involved in the person centred planning of their care and support prior to moving to Mount Denys. Individuals or their representative(s) are supported to identify potential risks and how these can best be managed by the service Existing Individuals are protected from abuse/ potential abuse from inappropriate admissions.	**11/8/11** Teresa Harrison, Practice Manager, Compliance Lead/ Sue Reilly, RMN,Practice Manager, Mental Health Lead	**COMPLETED**
		Spreadsheet log to be kept for all referrals to include conversations relating to possible admissions including records of when referrals are refused because they are inappropriate. Risks to existing service users/ staff must be detailed and inform decision around	Individuals receive the levels of staffing required to meet each individuals needs. Existing Individuals are protected from abuse/ potential abuse from inappropriate admissions.	**5/8/11** Janice Phillips, Registered Manager/ Sue Reilly, RMN, Practice Manager, Mental Health Lead/Teresa Harrison, Practice Manager, Compliance Lead	**COMPLETED**

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		accepting/ declining referral. All records detailed above to be completed in full and signed and dated	Individuals receive the levels of staffing required to meet their needs.		
	3. Inspectors were concerned to learn that two people who had entered the 'Respite' unit some years ago were still there. There was no evidence that discussions' had taken place with either of the 'people' concerned or their relatives'/representatives' in respect to making the placement permanent	Accommodation need and situation to be clarified as part of the review process for all service users at Mount Denys.	Following emergency admissions the Individual, their representatives, and the care manager are involved in the person centred planning of their care and support within 24hours to ensure their support needs can be met by the service.	**15/8/11** Sue Reilly, Practice Manager, RMN, Mental Health Lead/Teresa Harrison, Practice Manager, Compliance Lead/ Social Workers, Adult Social Care Assessment and Care Management Team	**COMPLETED**
		Process/protocols to be agreed with ACM teams in respect of emergency admissions for review after 6 weeks for future accommodation need. Outcomes to be clearly detailed in individual support plan.	Existing Individuals are protected from abuse/ potential abuse from inappropriate admissions. Individuals receive the levels of staffing required to meet their needs.	**15/8/11** Sue Reilly, Practice Manager, RMN, Mental Health Lead/Teresa Harrison, Practice Manager, Compliance Lead/ Social Workers, Adult Social Care	**COMPLETED**

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	.	Occupational Therapist to undertake assessment of current call bell system to ensure fit for purpose and/or make recommendations for improvements.	Individuals are able to call for assistance using equipment appropriate to their needs and abilities	30/9/11 Sue Reilly RMN,Practice Manager, Mental health lead/ Audrey Franks, Operations Manager/ Mark Butterworth, Practice Manager/Occupational Therapy/ Kim Green Physiotherapist	Individuals are being assessed for access to call bells. Alternatives being identified where required.
Outcome 4 - other evidence from Compliance Review	Lack of activities/lack of stimulation visually/environment	Review of the current activity programmes on offer with involvement from all service users and families, using implemented accessible information. Review of staffing numbers. The schedule for current ongoing improvement works to be kept in main office at Mount Denys	Individuals continue to receive support from skilled, trained and competent staff in sufficient numbers. A pleasant stimulating environment is created for service users. A flexible, responsive activity programme will be available that meets individual needs, including 1:1 interaction.	Date for work to commence to be agreed with Estates Tony Jackson, Estates Manager **30/9/2011** Janice Phillips, Registered Manager **21.10.11** Mark Butterworth Practice Manager/Occupational Therapist	Environment reviewed with Estate Department; Raised beds to be put in the garden for flowers/vegetable growing to enhance 1:1 activity and stimulation. Architects drawings received for approval The sitting room upstairs is being refurbished for stimulation activity. The lounge downstairs is being re – organised to enhance visual stimulation involving the garden area. Occupational Therapy/Physiotherapist assessments commenced on 19.8.11.for each individual to plan programme of physical stimulation/activity. Training for staff to stimulate this category of service users has been completed. Further specialist training has been commissioned. Individuals who do not get involved

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
					in activities have 1:1 interaction. Recruitment commenced for skilled staff. Agency staff, skilled in Older People mental health care being used in the interim. There will be monthly therapy clinics held to identify therapeutic needs and agreed activity plans for service users led by Practice Manager/OT Mark Butterworth.
	Lack of evidence of routine nutritional assessment to highlight malnutrition/de hydration	Malnutrition Universal Screening Tool to be included alongside each service users support plan.	Individuals will have their support needs met with regard to nutrition and hydration through regular assessment, and the seeking of guidance/professional support as required	**30/8/11** Sue Reilly RMN, Practice Manager, Mental Health Lead/Janice Phillips, Registered Manager **5/9/11** John Figgins, Catering Manager	Malnutrition Universal Screening Tool assessments are undertaken for all service users. Waterlow assessments are also undertaken for service users. Referrals are being made to a dietician for those identified at risk of malnutrition. Menus will be revised and cater for all dietary needs i.e. vegetarians.
	Falls prevention	Risks to service users to be clearly identified (Initial risk profile) and actions taken to reduce risks clearly detailed on	Individuals have person centred support plans in place agreed with them, or their representatives, clearly	Janice Phillips, Registered Manager/Debbie Greathead, Deputy Manager.	All service users have falls risk assessments undertaken which are reviewed on a regular basis. All documentation is kept on the service users' support plans.

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		all individual risk assessments. Reviews and updates to be clearly detailed	setting out their support needs, choices and preferences and how these are met, taking into account risks to the individual.		**COMPLETED**
	Lack of evidence of body maps	Review of incident recording form to include body map for completion when necessary	Incidents and risk to individuals are monitored to identify trends and patterns, highlighting areas of concern for reporting and responding to immediately thereby ensuring the safety of the individual is maintained.	Janice Phillips, Registered Manager	Body maps are now included on the reporting form for incidents. **COMPLETED**
	Restrictive Physical Interventions – lack of detail	Restrictive Physical Interventions drawn up to be personalised for each individual service user will detailed information relating to the reasons for use of the RPI.	Levels of incidents experienced by individuals are reduced. Individuals will receive support from representatives/ professionals to identify and provide a co-ordinated person centred approach to ensure individual needs are met and safeguarded.	**6/9/2011** Joanna Boddy, Sue Reilly RMN, Practice Manager, Mental Health Lead	The Practice Manager, RMN is working with psychiatrists and mental health assessment teams and user representatives to develop guidance to ensure best practice in applying physical interventions. Reasons for RPI will be documented on individual care plans.

Outcome 4 (Regulation 9) **Care and Welfare of Service users**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	Incontinence management	Service Users who may benefit from an incontinence plan to be identified and any action plans recorded on individual care plans	Individuals will have their support needs met with regard to incontinence through regular assessment, and the seeking of guidance/professional support as required	**31.10.11** Janice Phillips, Registered Manager/Incontinence Nurse, PCT	Identify service users at risk of incontinence, agree programme to manage this seeking the advice of the incontinence advisory nurse. The action plan for managing a service user's incontinence will be on individual care plans. Training is planned for all staff in managing incontinence

Outcome 5

Outcome 5 (Regulation 14) Meeting Nutritional needs	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 **Outcome 5 – Meeting Nutritional Needs** **What the outcome says** This is what people who use services should expect. People who use services: * Are supported to have adequate nutrition and hydration.	People in the home were not provided with accessible information about menus and choice was limited. The specific dietary needs of people in the home were not always well supported. People do not have access to drinks outside of normal meal times and tea breaks and were at risk of not being properly hydrated. Body weights were inconsistently recorded. Overall we found Mount Denys was not meeting this essential standard .	Support plans to identify MUST and specific nutritional guidance as for Outcome 4, with additional reference to monitoring weight as part of this process as appropriate.	Individual's nutrition and hydration needs are clearly identified and met.	**5/8/11** Janice Phillips,Registered Manager/Sue Reilly,RMN ,Practice Manager, Mental Health Lead	**COMPLETED**
			Individual nutrition needs/ preferences and lifestyle choices are catered for and provide sufficient choices for individuals whilst meeting their nutritional needs and maintaining a healthy lifestyle.	**30/8/11** Sue Reilly, RMN, Practice Manager, Mental Health Lead.	**Work commenced**
		Accessible information to be made available to promote choice and control and involvement wherever possible of service users in their day to day lives. (Service User Involvement Worker) Information to be available e.g. menus, accessible lists for available snacks/drinks for service users to be placed in units.	Individuals are able to make informed choices about the meals they would like to eat and are able to make informed choices about what snacks and drinks they would like and when they would like it and to inform staff.	**1/8/11** Teresa Harrison, Practice Manager, Compliance lead/ Lisa Gyalog, Service User Involvement Worker	**COMPLETED**

Outcome 5 (Regulation 14) Meeting Nutritional needs	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		Occupational Therapy support to be sourced to undertake assessment of current equipment available to service users to be independent in eating and drinking and make recommendations for any additional equipment.	Individuals will be able to call and summon help as they need to with the right equipment available to support their needs and abilities.	**30/9/11** Sue Reilly RMN,Practice Manager, Mental Health Lead/ Audrey Franks, Operations Manager/ Mark Butterworth, Practice Manager	**Work commenced**
		(Please also see actions relating to Outcome 1 & Outcome 4)			
Outcome 5 - other evidence from Compliance Review	Additional finger food availability	Accessible information to be made available to promote choice and control and involvement wherever possible of service users in their day to day lives. (Information to be available e.g. menus, accessible lists for available snacks/drinks for service users to be placed in units.	Individuals are able to make informed choices about the meals they would like to eat and are able to make informed choices about what snacks and drinks they would like and when they would like it and to inform staff.	**5/9/11** John Figgins, Catering Manager/Alison Turner, Cook	The menu review will include a choice of finger foods.

Outcome 5 (Regulation 14) Meeting Nutritional needs	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
	Flexibility of choosing midday meal	Service users will be asked prior meal times about their Stocks of ingredients will be ordered/maintained to meet the Service users' meal choices.	Individuals are able to make informed choices about the meals they would like to eat at each mealtime.	Janice Phillips, Registered Manager	Service users will be asked to choose their midday meal at mealtimes as enough options will be available **COMPLETED**

Outcome 6

Outcome 6 (Regulation 24)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 **Outcome 6 – Cooperating with other providers** **What the outcome says** This is what people who use services should expect. People who use services: * Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.	The service could not evidence the routine involvement of other health and social care professionals in respect of strategies for working with people in the home. Overall we found Mount Denys was not meeting this essential standard. .	(Please see actions relating to Outcomes 2, 4, 7 & 16)	By Involving other health & Social Care professionals, the individual have been benefitting from a multi agency approach to person centred support planning and delivery. Individuals will benefit from co-ordinated care and support to ensure all their needs, preferences, and choices are met. The individual will benefit from skilled and informed staff and other professionals in how these needs are met		

Outcome 7

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
Failing to comply with Regulation 11(1)(a)(b)(2)(a)(b)(3)(a)(b)(c) (d)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states **11. (1) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of –** **(a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and** **(b) responding appropriately to any allegation of abuse.** **(2) Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against**	1. It was found that suitable arrangements had not been made to ensure that people who use the service are safeguarded against the risk of abuse, or that allegations of abuse are responded to appropriately	Revise current processes and procedures for recording, monitoring and address the lack of reporting of incidents under safeguarding procedures. Implement DPS Manager Incident recording form for service user to service user incidents. Form has been amended to reflect guidance that all these incidents must be raised as Safeguarding Adults at Risk alerts and Notifications sent to CQC.	Individuals are supported to be safe and their health and wellbeing maintained.	**29/7/11** - Janice Phillips, Registered Manager/ Sue Reilly, Practice Manager, RMN, Mental Health Lead **26/7/11 & ongoing** Janice Phillips, Registered Manager	**COMPLETED** **COMPLETED**
	2. Records showed a significant number of physical violence incidents involving people living at the home also incidents of sexual abuse and also incidents where service users had been found with objects in their mouths.	DPS Manager to ensure all incidents are investigated and actions taken to identify triggers, trends, minimise risk and to prevent reoccurring incidents.	Incidents of potential/actual abuse are reported immediately following immediate action taken to safeguard the individual and investigated to ensure the continuing safety of the individual is maintained and the risk of re-occurrence reduced.	**29/7/11** - Janice Phillips, Registered Manager/ Sue Reilly, Practice Manager,RMN,, Mental health lead	**COMPLETED**

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
the risk of such control or restraint being – **(a) unlawful; or** **(b) otherwise excessive** **(3) For the purposes of paragraph (1), "abuse", in relation to a service user, means** **(a) sexual abuse;** **(b) physical or psychological ill-treatment;** **(c) theft, misuse or misappropriation of money or property; or** **(d) neglect and acts of omission which cause harm or place at risk of harm**			Incidents and risk to individuals are monitored to identify trends and patterns, highlighting areas of concern for reporting and responding to immediately thereby ensuring the safety of the the individual is maintained. Levels of incidents experienced by individuals will be reduced. All incidents of abuse/potential abuse experienced by individuals are alerted through the Safeguarding process.		
	4. Only four of the seventy incidents recorded in May have been reported through established safeguarding channels in line with local and national policy and guidance	Processes have been revised and guidance given to ensure that reporting alerts and notifying to CQC are carried out in accordance with current instructions i.e. all incidents relating to abuse, suspected or potential abuse, are raised as SAR alerts and notified to CQC at the same time	The individual will be assured to know that the regulatory body, the Care Quality Commission, is aware of all safeguarding activity within the home.	**25/7/11** Janice Phillips, Registered Manager/ Sue Reilly, RMN Practice Manager, Mental Health Lead	**COMPLETED**

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	3. Only three of the seventy incidents recorded in May had been reported to CQC as statutory notifications. This demonstrates that allegations of abuse are not responded to appropriately.	All notifications to contain detailed relevant information on incidents including how, where, when, what, who, immediate action taken to safeguard individual, relevant information preceding incident/history, investigations undertaken, alerts raised and longer term action taken to safeguard individuals involved - All notifications to be cc to Teresa Harrison & Michele Etherton - SAR log to be kept to detail outcomes of alerts raised. Incident log to include columns for identifying when SAR alert raised & notification sent to CQC.	Incidents and risk to individuals are monitored to identify trends and patterns, highlighting areas of concern for reporting and responding to immediately thereby ensuring the safety of the individual is maintained. Levels of incidents experienced by individuals will be reduced.	**26/7/11** Janice Phillips, Registered Manager/ Sue Reilly, RMN Practice Manager, Mental health lead **26/7/11 & ongoing** Janice Phillips, Registered Manager **26/7/11** Janice Phillips, Registered Manager **26/7/11** Janice Phillips, Registered Manager **26/7/11** Janice Phillips, Registered Manager	**COMPLETED** **COMPLETED** **COMPLETED** **COMPLETED**
	5. When we reviewed incidents, many were recorded as witnessed by staff. We were concerned to note that a number showed a	Weekly analysis to be undertaken by DPS Manager to look at patterns, trends, potential triggers and identify further actions	Individuals are supported to be safe and their health and wellbeing maintained. Incidents of	**29/7/11** Janice Phillips, Registered Manager	**COMPLETED**

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	clear escalation from an initial argument to an act of physical violence, and yet staff were not aware of the indicators of possible aggression and did not react in a timely manner to de-escalate situations, and minimize the likelihood of physical violence.	required to manage and reduce levels of incidents.	potential/actual abuse are reported immediately following immediate action taken to safeguard the individual and investigated to ensure the continuing safety of the individual is maintained and the risk of re-occurrence reduced. Incidents and risk to individuals are monitored to identify trends and patterns, highlighting areas of concern for reporting and responding to immediately thereby ensuring the safety of the the individual is maintained.		
	6. Expressed concern to the registered manager that there was a culture of violence in the home. There was no clear strategy for reducing the level of violence in the home. This demonstrates that suitable arrangements to ensure people are safeguarded against the risk of abuse are not in place.	Staff competencies and training in SAR to be checked – additional brief bite training to be arranged for shortfalls in training/competencies identified until training courses can be attended/commissioned.	Levels of incidents experienced by individuals will be reduced. All incidents of abuse/potential abuse experienced by individuals are alerted through the Safeguarding process. Individuals will benefit from a skilled staff team	**15/8/11** Teresa Harrison, Practice Manager, Compliance lead/ Wendy Charlesworth QCF lead and Training team.	**COMPLETED**

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
			who are competent in all mandatory training, including Safeguarding, refreshers/updates and have undergone competency checks to ensure Individuals receives quality care and support. Individuals receive appropriate levels of individualised support from skilled and competent staff.		
		Strategy meeting held on 25/7/11 with regard to safeguarding non compliance raised by CQC. Outcomes are: - all service users will have a full review including psychiatrist/mental health nurse involvement - Review of all service users' medications (staged approach) – Service Users's identified involved in high levels of incidents. Service Users with lower level of	Individuals will receive support from multi agency professionals to identify and provide a co-ordinated person centred approach to ensure individual needs are met and safeguarded. Individuals will be supported to identify the most appropriate accommodation to meet their needs. Individuals are supported to receive appropriate levels of medication to manage their condition/ behaviours.	**In progress** Adult Social Care Assessment and Care Management Team/Mental Health Team **9/8/11** Mental Health Team/ Sue Reilly,RMN, Practice Manager, Mental Health Lead **22/8/11** Martin Robinson. Head of Service, Adult Social Care Mental Health Team/Social Workers Community Mental Health Team/Jenny Ryan, Investigation Manager for	**COMPLETED** **COMPLETED**

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		involvement in incidents.- Safeguarding plan will look holistically at service user groups and dynamics at Mount Denys. - Psychiatrist from mental health team to be invited to next strategy meeting (5th Aug) to discuss introduction of multi-agency monthly review meeting for residents with complex needs.	Individuals will receive support from multi agency professionals to identify and provide a co-ordinated person centred approach to ensure individual needs are met and safeguarded.	Safeguarding Investigation.	**COMPLETED** Strategy Meeting held. **COMPLETED**
	7 Individualised behaviour management guidance to inform staff was minimal where it existed. There was a failure to provide staff with a detailed strategies or guidelines for the consistent and safe management of challenging behaviours.	Specific strategies and guidelines for individual service users for challenging behaviour and vulnerability. Format to be agreed to include preventative measures, warning signs, triggers, diversion and de-escalation techniques. Support from Amelia Culshaw	Staff are able to understand and provide timely and effective interventions to manage individual behaviours and optimise safety and wellbeing of individuals. Skilled staff will understand and be competent in the use of diversion techniques and de-escalation to support the individual to manage their	**29/7/11** Teresa Harrison, Practice Manager, Compliance lead/Sue Reilly,RMN, Practice Manager, Mental Health lead/Janice Phillips, Registered Manager	A "Positive Behaviour Support Plan" has now been identified and introduced for individual service users. The form allows information relating to warning signs/triggers, diversion and de-escalation techniques to be recorded. There is also monitoring tool within the form which allows recording of when the strategies/guidelines are used. This will allow for analysis and tracking of the effectiveness of the strategies/guidance in place. **COMPLETED**

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		(trainer) to be sourced.	behaviours Levels of incidents experienced by individuals will be minimised.		
	9. Physical intervention approvals were in place for some people, but these provided no information about what level of restraint was to be used, when it was to be used, how many staff would be involved, whether this had been approved within a Best interest meeting to ensure the rights of the person were protected, or how frequently this was to be reviewed	Any RPIs drawn up to be personalised for each individual service user and accompanied by a Supported decision Making process form. Also needs to be noted that RPI action is last resort after trying all guidance/strategies for the individual service user.	Individuals will receive support from representatives/ professionals to identify and provide a co-ordinated person centred approach to ensure individual needs are met and safeguarded. Individuals will experience RPI as a last resort.	**29/7/11** Teresa Harrison, Practice Manager, Compliance lead/Sue Reilly, RMN,Practice Manager, Mental Health lead/Janice Phillips, Registered Manager	**COMPLETED**
Outcome 7 - other evidence from Compliance Review	Staff trained in Safeguarding Adults at Risk	Staff competencies and training in SAR to be checked – additional brief bite training to be arranged for shortfalls in training/competencies identified until training courses can be attended/commissioned	Levels of incidents experienced by individuals will be reduced. All incidents of abuse/potential abuse experienced by individuals are alerted through the Safeguarding process. Individuals will benefit	**30/9/11** Janice Phillips, Registered Manager/Debbie Greathead, Deputy Manager	All permanent staff completed on line training in November 2009 which is repeated within two years. 75% completed on-line training, 50% completed Safeguarding Adults at Risk competencies and 33% completed safeguarding workshops All staff will have refresher training in safeguarding and incident reporting by 30 September 2011.

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
			from a skilled staff team who are competent in all mandatory training, including Safeguarding, refreshers/updates and have undergone competency checks to ensure Individuals receives quality care and support.		
	' Incidents and Culture of physical and verbal violence between residents and staff' Staff failed to recognise indicators of escalation or provide timely intervention to de-escalate Other incidents. Details of Restrictive Physical Intervention approvals (44 incidents of violence across all units service user to service user and 26 reported violent incidents towards staff)	Specific strategies and guidelines for individual service users for challenging behaviour and vulnerability. Format to be agreed to include preventative measures, warning signs, triggers, diversion and de-escalation techniques. Support from Amelia Culshaw (trainer) to be sourced.	Individuals will receive support from representatives/ professionals to identify and provide a co-ordinated person centred approach to ensure individual needs are met and safeguarded. Individuals will experience RPI as a last resort.	Sue Reilly, RMN, Practice Manager, Mental Health Lead **16/8/11 and ongoing Janice Phillips/ Pat Boland, Andrew James , Jackie Sellens, Gail Allam, Senior Care Officers**	Staffing at Mount Denys has increased by 11 staff, including an additional Senior Care Officer. Staff have received instruction in reporting incidents and safeguarding. Staff have been trained in individual service users triggers so they can intervene effectively to avoid harm and abuse. Number of incidents have reduced month by month regarding service user on service user violent incidents. In comparison to number of incidents quoted by CQC at inspection, current figures for 1st to 19th August show– 10 incidents of service user to service users 6 incidents of service users on staff Staff have been made aware of the importance of recognising and recording all incidents. **COMPLETED** All RPIs have been reviewed and relevant best interest discussions have been held. The RPI strategies will be monitored and reviewed

Outcome 7 (Regulation 11)	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
					regularly for effectiveness on a monthly basis or as required.
	Minimal guidance detail in care plans to manage challenging behaviour	Specific strategies and guidelines for individual service users for challenging behaviour and vulnerability. Format to be agreed to include preventative measures, warning signs, triggers, diversion and de-escalation techniques. Support from Amelia Culshaw (trainer) to be sourced.	Individuals will receive support from representatives/ professionals to identify and provide a co-ordinated person centred approach to ensure individual needs are met and safeguarded. Individuals will experience RPI as a last resort.	**29/7/11** Teresa Harrison, Practice Manager, Compliance lead/Sue Reilly, RMN, Practice Manager, Mental Health lead/Janice Phillips, Registered Manager/Amelia Culshaw/Trainer consultant	A "Positive Behaviour Support Plan" has now been identified and introduced for individual service users and included in their support plans. Staff have been made aware of the importance of identifying triggers of challenging behaviour in individuals and strategies for dealing with this has been details in individuals' care plans as well as discussed in the teams. Ongoing training in this field is in progress **COMPLETED**

Outcome 8

Outcome 8 (Regulation 12) **Cleanliness and Infection Control**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 **Outcome 8 – Cleanliness and infection control** **What the outcome says** Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.	Staff and people in the home could be exposed to infection because appropriate systems were not in place to protect them. Overall we found that Mount Denys was not meeting this essential standard.	Immediate removal of soiled recliner chair	Individual's are not put at risk from the spread of potential infection. Individuals are not subjected to unpleasant surroundings	**25/7/11** Janice Phillips,Registered Manager	**COMPLETED**
		Review of the laundry facilities on laurel Unit to ensure protocols are in place to prevent sluicing and laundry activities occurring at the same time.	Individuals are protected from the possible risk of cross infection.	**30/8/11** Janice Phillips,Registered Manager	**COMPLETED**
		To ensure infection control training is covered under Mandatory training for all staff, including care and support staff.	The individual is supported by skilled staff to prevent the risk of possible infections.	**30.11.11** Teresa Harrison, Practice Manager, Compliance lead	Outstanding refresher Training for Infection Control have been booked and will be completed by end of November 2011
		To ensure infection control training is covered under Mandatory training for all staff, including care and support staff.	The individual will be protected from the potential risks from themselves and others, by the identification and control measures put in place to reduce risks.	**5/8/11** Teresa Harrison, Practice Manager, Compliance lead/Sue Reilly,RMN, Practice Manager, Mental health lead	**COMPLETED**
		Domestic staff to have clear roles and responsibilities. Cleaning Schedules to be in place detailing all areas of the building and equipment needing cleaning and frequency.	Staff are clear of their roles and responsibilities and cleaning is undertaken to cover all areas of the building and equipment regularly to minimise the risk of potential infections	**05/08/11** Janice Phillips, Registered Manager	**COMPLETED**

Outcome 8 (Regulation 12) **Cleanliness and Infection Control**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		Implementation of Staff observations as part of supervision process to monitor practice and ensure competency in role. To be cross referenced to competency in infection control procedures. (Please see actions in relation to Outcome 13 & 14)	Individuals receive appropriate levels of support from skilled and competent staff.	**5/8/11** Janice Phillips Registered Manager/Teresa Harrison, Practice Manager, Compliance lead	**COMPLETED**
Outcome 8 - other evidence from Compliance Review	Cleanliness of bedrooms lounge ,kitchens and floors	Domestic staff to have clear roles and responsibilities. Cleaning Schedules to be in place detailing all areas of the building and equipment needing cleaning and frequency.	Staff are clear of their roles and responsibilities and cleaning is undertaken to cover all areas of the building and equipment regularly to minimise the risk of potential infections Individuals are not put at risk from the spread of potential infection. Individuals are not subjected to unpleasant surroundings	Janice Phillips/Registered manager/Andrew James,Pat Boland/Jackie Sellings/Gail Allam, Senior Care Officers	A cleaning schedule was already in place and now all cleaners have been reminded of the schedules and their duties and responsibilities including cleaning hoists and wheelchairs. Stained chair has been disposed of. New flooring has been put in throughout the downstairs lounge and corridors, air purifiers are in use throughout the home. **COMPLETED.**
	Service User with MRSA infection	To ensure infection control training/first aid is covered under Mandatory training for all staff, including care and support staff.	Individuals are protected from the possible risk of cross infection. Individuals receive appropriate levels of support from skilled and competent staff.	**30/9/11** Sharon Hulme, RGN Joint Health and Social Care Manager	Initial risk assessments at Mount Denys will identify any infectious conditions. Appropriate controls will be put in including staff trained in Infection Control procedures and their practice monitored though supervision observations implemented on 8.8.11 **COMPLETED**

Outcome 8 (Regulation 12) **Cleanliness and Infection Control**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	First Aid training and infection control training not put into practice	To ensure infection control training is covered under Mandatory training for all staff, including care and support staff.	Individuals receive appropriate levels of support from skilled and competent staff.	Janice Phillips/Registered Manager/Debbie Greathead, Deputy Manager, Andrew James,Pat Boland/Jackie Sellens/Gail Allam, Senior Care Officers .	Refresher training for Infection Control and First aid have been booked for staff and their practice will be observed through supervision observations implemented on 8.8.11 **COMPLETED**

Outcome 9

Outcome 9 (Regulation 13) **Management of Medicines**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 **Outcome 9 Management of Medicines** **What the outcome says** This is what people who use services should expect. People who use services: * Will have their medicines at the times they need them, and in a safe way. * Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.	People are not having their medication needs reviewed by a specialist in line with their complex needs. Overall we found that Mount Denys was not meeting this essential standard	Review of all service users' medications (staged approach) – SU's identified involved in high levels of incidents. SU's with lower level of involvement in incidents.	Individuals will receive appropriate levels of medication to support them to manage their behaviours and conditions, by involving specialist health professionals as part of a multi disciplinary approach to meet individual needs including appropriate levels of medication	**9/8/11** Mental Health Team/ Sue Reilly,RMN, Practice Manager, Mental health lead	COMPLETED
Outcome 9 - other evidence from Compliance Review	Service uses not having medication reviewed by specialists in line with their complex needs	Review of all service users' medication to be undertaken.	Individuals will receive appropriate levels of medication to support them to manage their behaviours and conditions, by involving specialist health professionals	**23/8/11 by** Dr Mutiboku/Consultant Psychiatrist, Conquest Hospital	Medication reviews have been carried out for all service users and changes have been recorded on support plans **COMPLETED**

Outcome 9 (Regulation 13) **Management of Medicines**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
			as part of a multi disciplinary approach to meet individual needs including appropriate levels of medication		

Outcome 10

Outcome 10 (Regulation 15) **Safety and Suitability of Premises Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Outcome 10 Safety and Suitability of premises** **What the outcome says** This is what people should expect. People who use services and people who work in or visit the premises: * Are in safe, accessible surroundings that promote their wellbeing.	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
	The general environment was stark, and unstimulating. People's activity routine had been disrupted owing to improvement works. People were not provided with necessary support to use call bells effectively. People were at risk of trips and falls through only part removal of carpeting. Overall we found that Mount Denys was not meeting this essential standard.	The schedule for current ongoing improvement works to be kept in main office at Mount Denys	A pleasant stimulating environment is created for service users.	**30/9/11** Janice Phillips, Registered Manager, Audrey Franks, Operations Manager/ Chris Doran, Project Manager	**Work commenced**
		The schedule for current ongoing improvement works to be kept in main office at Mount Denys Risk assessments to clearly detail controls in place to minimise disruption and risk to service users during improvement works	Individuals or their representative(s) will be consulted by managers prior to works being undertaken to minimise anxiety, risk and impact	**30/9/11** Janice Phillips, Registered Manager, Audrey Franks, Operations Manager	**Work commenced**
Outcome 10 - other evidence from Compliance Review	In some bedrooms, beds were away from the wall and could result in a service user falling down the side of the bed, away from a call bell	Bedrooms to be risk assessed to highlight any risks to service users falling between beds and wall. Beds to be moved accordingly to avoid risk to users falling	Individuals are supported to be safe and their health and wellbeing maintained.	Janice Phillips/, Registered Manager	.**COMPLETED**

Outcome 13

Outcome 13 (Regulation 22)	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
Failing to comply with Regulation 22, which states: 22 In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.	1. Appropriate steps had not been taken to provide sufficient numbers of suitably qualified, skilled and experienced staff to ensure that people living in the home were receiving safe and appropriate, personalised care, treatment and support.	Staffing level risk assessment to be reviewed continually and changes to staffing as a result, recorded. • Must be reviewed prior to admission of any service users new to the service. Comprehensive review of Mount Denys Rotas and staffing to be undertaken and recommendations made in relation to staffing structure needed	Individuals will receive support from skilled and experienced staff, in sufficient numbers, who understand them and are able to meet their needs. Individuals are supported by staff in sufficient quantities to meet their needs and protect them from abuse/potential abuse.	**29/7/11** Janice Phillips, Registered Manager/ Sue Reilly,RMN ,Practice Manager, Mental health lead **15/8/11** Shane Heber, Head of Service, Directly Provided Service/ Beverly Scott, Interim Deputy Head of Service, Directly provided Services/ Janice Phillips, Registered Manager/ Sue Reilly,	**COMPLETED** and ongoing **COMPLETED**
	2 & 3. Staff were Interviewed. We were advised that two care staff support ten people on each unit during the day shift supported by a	Additional Agency/ relief staff to be utilised to ensure sufficient levels of staff are in place as identified on the staffing level risk assessment.	Individuals are supported through sufficient staffing levels and expertise to meet their needs and protect them from	**29/7/11** Janice Phillips, Registered Manager	**COMPLETED**

Outcome 13 (Regulation 22)	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
	floating care staff member across all three units. A senior staff member is available to each unit in the event of an emergency. On paper this sounds like a sufficient number of staff. However, documentary evidence supplied by Mount Denys in respect of the incidents of physical and verbal violence that have occurred during the period 1st-31st may 2011, indicated an unacceptable level of violence between people living in the home and toward staff. Forty four incidents of physical violence between people living in the home, with an additional twenty-six incidents of physical violence towards staff were recorded	Additional agency admin staff to be sourced to support implementation of databases for recording information and implementing processes to monitor, review and up date records as required. Admin from other DPS service (CSS) to be utilised to implement 1 – 13 compliance files in Mount Denys and share existing spreadsheets for monitoring records e.g. training, risk assessments, support plans, reviews and monitoring DPS Manager to ensure all incidents of violence towards staff continues to be investigated and actions taken to identify triggers, trends, minimise risk and to prevent reoccurring incidents are clearly recorded.	abuse/potential abuse. Incidents of abuse/potential abuse are minimised.	**27/7/11** Janice Phillips, Registered Manager/ Sue Reilly, RMN,Practice Manager, Mental health lead **29/7/11** Teresa Harrison, Practice Manager, Compliance lead **29/7/2011** Janice Phillips, Registered manager	**COMPLETED** **COMPLETED** **COMPLETED**

Outcome 13 (Regulation 22)	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
	4. A review of incident reports indicated that staff lack the necessary skills and experience to effectively manage challenging behaviour from people living in the home, are failing to recognise indicators of aggression and de-escalate situations. This demonstrates that there are insufficient numbers of skilled and experienced persons employed for the purposes of carrying on the regulated activity	Staff competencies and training to be checked – additional brief bite training to be arranged for shortfalls in training/competencies identified particularly around Infection Control, Challenging Behaviours, (de-escalation techniques, triggers etc) Person centred approaches, identifying risk, DOLS, SAR, MCA and Dementia. All mandatory training and competencies to be checked and brief bite sessions arranged until training courses can be attended/ commissioned. All staff to be brought up to date with all mandatory training Staff Meetings to be called for Seniors & All staff to support role out of all the required actions.	Individuals receive appropriate levels of individualised support from skilled and competent staff. Individual's will receive support from staff that are skilled in Infection Control Measures and how to prevent cross infection; Challenging Behaviours and how to recognise and how to positively manage behaviours, identify triggers, patterns' and de-escalation techniques; Person centred approaches and how to ensure the individual is at the centre of the support they receive; Staff that can identify risks and working with the individual to put in controls to reduce risk; MCA/DOLS awareness including how to seek support when these are identified/required. Staff who can recognise abuse and potential abuse and report this through alerting procedures; Dementia awareness.	**5/8/11** Teresa Harrison, Practice Manager, Compliance lead/ Wendy Charlesworth/ Sue Howell/ Amelia Culshaw, Training Consultants **30/9/11** Janice Phillips, Registered Manager/ Sue Reilly RMN,Practice Manager, Mental health lead **29/7/11** Janice Phillips, Registered Manager/	Training gaps now identified and following arranged. DOLS/MCA/Best interest decisions – brief bite sessions commenced 28.7.11 and will continue until all staff have attended (by 30.9.11) First Aid awareness – booked for 5.8.11 to cover all those staff awaiting refresher training. SAR – being covered by Competencies being updated starting week beginning 1.8.11. SVA lead has been to visit staff, competencies being reviewed 1 – 15 and changes to new policy/ procedures. Infection Control – negotiating with trainer to deliver training for staff awaiting refresher. One member of staff who has not received any training has been given training DVD to watch until attending accredited training in August 11. Dementia training – trainer identified who is putting programme together aimed specifically at Mt Denys staff. Training has commenced. A fully updated Training spreadsheet will be finalised with all updated training and refreshers booked week beginning 8.8.11 COMPLETED Medication competencies – **COMPLETED**

Outcome 13 (Regulation 22)	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
				Sue Reilly,RMN Practice Manager, Mental health lead	All staff are attending training as identified above and being booked onto other training as a matter of urgency Nutrition and Hydration quiz being undertaken by staff whilst waiting for formal training Meetings with Seniors and all Staff have been held, also sent memos outlining current position to all staff. **COMPLETED**
		Implementation of Staff observations as part of supervision process to monitor practice and ensure competency in role. To be cross referenced to competency frameworks for SAR & Medications and competency in infection control procedures		**5/8/11** Janice Phillips Registered Manager/Teresa Harrison, Practice Manager, Compliance lead	**COMPLETED**

Outcome 14

Outcome 14 (Regulation 23) **Supporting Staff**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 **Outcome 14 – supporting 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 competent staff.	There was a programme of training in place for staff but not all staffing had completed their mandatory training. There was no evidence to indicate that staff competencies in regard to understanding the needs of people with dementia and managing behaviour effectively were routinely assessed and people in the home could be exposed to unnecessary risk because of this. Overall we found that Mount Denys was not meeting this essential standard.	Staff competencies and training to be checked – additional brief bite training to be arranged for shortfalls in training/competencies identified particularly around Infection Control, Challenging Behaviours, (de-escalation techniques, triggers etc) Person centred approaches, identifying risk, DOLS, SAR, MCA and Dementia. All mandatory training and competencies to be checked and brief bite sessions arranged until training courses can be attended /commissioned.	Individuals receive appropriate levels of individualised support from skilled and competent staff. Individual's will receive support from staff that are skilled in Infection Control Measures and how to prevent cross infection; Challenging Behaviours and how to recognise and how to positively manage behaviours, identify triggers, patterns' and de-escalation techniques; Person centred approaches and how to ensure the individual is at the centre of the support they receive; Staff that can identify risks and working with the individual to put in controls to reduce risk; MCA/DOLS awareness including how to seek support when these are identified/required. Staff who can recognise abuse and potential abuse and report this through alerting procedures; Dementia	**5/8/11** Teresa Harrison, Practice Manager, Compliance lead/ Wendy Charlesworth/ Sue Howell/ Amelia Culshaw, Training Consultants	**COMPLETED**

Outcome 14 (Regulation 23) **Supporting Staff**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
			awareness.		
		All staff to be brought up to date with all mandatory training	Individuals will benefit from a skilled staff team who are competent in all mandatory training, refreshers and have undergone competency checks to ensure Individuals receives quality care and support	30/9/11 Janice Phillips, Registered Manager/ Sue Reilly RMN,Practice Manager, Mental health lead	All staff are attending training as identified above and being booked onto other training as a matter of urgency
		Implementation of Staff observations as part of supervision process to monitor practice and ensure competency in role. To be cross referenced to competency frameworks for SAR & Medications and competency in infection control procedures	Individuals receive appropriate levels of individualised support from skilled and competent staff.	**5/8/11** Janice Phillips Registered Manager/Teresa Harrison, Practice Manager, Compliance Lead	**COMPLETED**
		Spreadsheets/ Log to be developed and held centrally to enable managers to monitor and keep staff training/ appraisals & development plans reviewed and up to date	Individuals will receive support from skilled and confident staff.	**9/9/11** Janice Phillips, Registered Manager	Work commenced
Outcome 14 - other evidence from Compliance Review	Unclear how many staff had achieved NVQ Level 2	Spreadsheets/ Log to be developed and held centrally to enable managers to monitor	Individuals will receive support from skilled and confident staff.	Rolling programme Wendy Charlesworth/QCF Lead	74% have completed level 2 and 3 NVQ. All care staff will be undertaking Quality Credit Framework . Modules relate to Risk and Choice in Dementia

Outcome 14 (Regulation 23) **Supporting Staff**	**Detailed failures identified in Compliance Review/Enforcement Notice**	**Required Action to ensure compliance**	**Outcome for the individual**	**Responsible person(s) and date**	**Progress made in meeting compliance requirements as at**
		and keep staff training/ appraisals & development plans reviewed and up to date		Commenced in August 2011	and Communication and Dementia
	Insufficient specific training/competencies in place for dementia care, Mental Capacity Act, Deprivation of Liberty, safe management of challenging behaviours, care planning or risk assessment.	All staff to be brought up to date with specific training for the complex needs of service users at Mount Denys	Individuals will receive support from skilled and confident staff.	**30/9/11** Janice Phillips, Registered Manager/ Sue Reilly RMN,, Practice Manager, Mental health lead	DOLS/MCA/Best interest decisions – brief bite sessions commenced 28.7.11 and will continue until all staff have attended Positive Behaviour Support Planning training commenced – will continue until all staff have attended. 1:1 sessions completed with staff regarding reporting and recording Safeguarding incidents- **COMPLETED**
	Supervisions had failed to identify or act on issues of repeated violence experienced by staff from residents	Implementation of Staff observations as part of supervision process to monitor practice and ensure competency in role. Updating of Supervision framework. Ensure that staff are suitably supported through supervision processes.	Individuals will receive support from skilled and confident staff who are supported through a robust supervision process	Janice Phillips, Registered Manager/ Sue Reilly RMN, Practice Manager, Mental health lead	The new framework for supervision now contains practice observations, training and development needs. All Senior Care Officers using the process to ensure staff are appropriately skilled and supported to carry out their duties. **COMPLETED**
	Development Plans for staff failed to identify and address training needs approrpriately.	Spreadsheets/ Log to be developed and held centrally to enable managers to monitor and keep staff training/ appraisals & development plans reviewed and up to	Individuals will receive support from skilled and confident staff.	Janice Phillips, Registered Manager/ Sue Reilly RMN, Practice Manager, Mental health lead	Sue Reilly has discussed the connection between annual appraisals and development for staff and addressing developments/training needs **COMPLETED**

Outcome 16

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
Failing to comply with Regulation 10, which states: **The registered person must protect service users, and others who may be at risk , against the risks of inappropriate care or unsafe care and treatment, by means of the effective operation of systems deigned to enable the registered person to:** **(a) regularly assess and monitor the quality of the services provided in the carrying out of regulated activity against the requirements set out in this Part of the Regulations and** **(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity**	1. It was found that appropriate steps had not been taken to ensure people in the home were protected by the effective operation of systems for quality monitoring of service delivery and effective management of risk.	Management to review current standards in relation to Quality Monitoring processes and develop new system with clear expectations and frequency for undertaking, alongside reporting systems for alerting senior managers.	Individuals and their representative(s) will be secure in a quality assurance process that identifies shortfalls in service delivery and performance continuously, and addresses this.	**29/8/11** - Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead	**COMPLETED**
	Full Compliance report to be undertaken at Mount Denys following immediate actions addressed (Following enforcement timescales).	Individuals and their representative(s) will benefit from a Quality Assurance Compliance monitoring process that highlights shortfalls in service delivery and performance. Areas for improvement will be identified and addressed to ensure Individuals health, safety and needs are met against each of the outcomes of the Essential Standards of Quality and Safety.	**9/9/11** - Teresa Harrison, Practice Manager, Compliance lead	**Work commenced**	
		Service User feedback system to be reviewed and updated to inform service provision. Advocacy to be	Individuals and their representative(s) are involved and contribute to the development and delivery of the service in	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager,	**Work commenced**

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		involved as necessary	meeting their needs.	Mental health lead/ Audrey Franks, Operations Manager	
		Relatives/Family Feedback system to be reviewed and updated to inform service provision	The Individual's Relatives/Family are involved and contribute to the development and delivery of the service in meeting their needs.	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN,Practice Manager, Mental health lead/ Audrey Franks, Operations Manager	**Work commenced**
	3. The views of health, social care, and other professionals visiting the home were not sought to inform quality monitoring.	Stakeholder Feedback System to be developed to inform service provision	Stakeholders are involved and contribute to the development and delivery of the service in meeting the Individuals needs. All of this results in service user having a much improved service which continually considers their needs as individuals.	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN,Practice Manager, Mental health lead/ Audrey Franks, Operations Manager	**Work commenced**
	4. If an effective operating system was in place the observations should have identified risks relating to the health, welfare and safety of the service users in order to assess and manage the same	Quality Assurance Feedback process and timetable to be clearly drawn up to support implementation of the above 3 key areas. Service Bulletins to be developed alongside above to inform/ feedback to service users, relatives, Stakeholders of	Individuals/ Stakeholders/ families/relatives are aware of how their contributions have contributed to the development and delivery of the service.	**9/9/11** Janice Phillips Registered Manager/Teresa Harrison, Practice Manager, Compliance lead	**Work commenced**

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		feedback and how this has informed service provision.			
		Implementation of Staff observations as part of supervision process to monitor practice and ensure competency in role. To be cross referenced to competency frameworks for SAR & Medications and competency in infection control procedures.	Service users receive appropriate levels of individualised support from skilled and competent staff.	**9/9/11** Janice Phillips, Registered manager	**COMPLETED**
	5. A check was made of the activities that have been provided and this was last recorded as checked in May 2011. This check, however, did not record the level of participation of those people in the home involved and did not record those who were not involved to make assessments about effectiveness and suitability.	Activity Monitoring and review to be a clear area within the Quality Assurance Process undertaken by DPS Managers Activities provided to be included in Service Users Meeting agendas and part of Service User Feedback System to ensure all views are captured to inform improvements in services.	Individuals are involved and contribute to the development and delivery of the service in meeting their activity needs. Individuals are involved and contribute to the development and delivery of the service in meeting their activity needs.	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead/ Audrey Franks, Operations Manager	**Work commenced**
	6. Service User meetings did not demonstrate how the	Service User Meetings to have clear agendas evidenced by	Individuals and their representative(s) are able to see outcomes	**9/9/11** Janice Phillips, Registered manager/	**Work commenced**

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
	views of service users were taken into account, or informed service development. If an effective operating system was in place a proper system to obtain the views expressed by the service users would be in place to help identify, assess and manage risks relating to the health, welfare and safety of the service users	contributions from Service Users on what they would like to discuss. Service User meetings to be written up clearly and to include feedback, comments from Service users on the service and changes made as a result. Accessible minutes/ visually displayed for all Service Users to see.	and discussions from service user meetings accessibly displayed, including how their contributions have contributed to the development and delivery of the service.	Sue Reilly RMN Practice, Manager, Mental health lead/ Audrey Franks, Operations Manager	
	7. A meals checklist/audit was in place but had not been completed and it was unclear what the home was monitoring.	Management to review the use of this and establish purpose. Monitoring of individual intake to be included as part of support plan under nutritional needs as required. Feedback on menus to be included as part of feedback system and service user meetings.	Individual will benefit from a holistic person centred support plan to detail areas of support needed and how this is achieved. Individuals are involved and contribute to the development and delivery of the service in meeting their nutritional needs and choices and quality of menus provided.	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead/ Audrey Franks, Operations Manager	**Work commenced**
	8. A Medicines audit dated 4/7/2011 was not completed.	Medication Audit to be undertaken to identify potential shortfalls in processes, procedures and training	Individuals are supported with their medication by skilled and competent staff who follow the correct	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN,Practice Manager,	COMPLETED

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		requirements to ensure compliance. Findings to be reported to Teresa Harrison, Practice Manager, Compliance lead/ Beverly Scott, Interim Deputy Head of Service, Directly Provided Services). Findings from Medication Audit to be implemented.	procedures for recording, storing, administering and disposing of medication.	Mental health lead/ Audrey Franks, Operations Manager	
	9. An audit check list was completed by senior staff including care plans, diary sheets, moving and handling, reviews, etc., however, the sheet viewed did not explain what was being checked for, and it was noted that ticks against medication and quality monitoring were absent	Management to review current standards in relation to Quality Monitoring processes undertaken by DPS Manager and develop new system with clear expectations and frequency for undertaking, alongside reporting systems for alerting senior managers.	Individuals will benefit from a Quality Assurance monitoring process that highlights shortfalls in service delivery and performance and areas of improvement to ensure Individuals health, safety and needs are met.	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN,Practice Manager, Mental health lead/ Audrey Franks, Operations Manager	**Work commenced**
	10. Care plans were not specifically individualised and were not supported by or informed by appropriate risk assessments. This was not picked up by the audits undertaken.	File auditing tool to be implemented across the service. File Audits and guidance to include checks on quality of support plans, risk assessments, personalisation, consent and	Individual records are kept up to date and reflect the current level of support, guidelines and identified risks/controls needed to meet their needs.	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead	**Work commenced**

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		involvement. All audit checklists to have prompt guidance attached to identify quality expected			
	11. The manager informed us that quality monitoring sheets were not used to inform the annual development plan for the service and it was unclear if one existed.	The registered manager will ensure the provider compliance assessment report is completed from the evidence recorded on Quality Assurance processes outline above. This will be available on request to senior management and CQC.	Individuals will benefit from a Quality Assurance Compliance monitoring process that highlights shortfalls in service delivery and performance and areas of improvement to ensure Individuals health, safety and needs are met against each of the outcomes of the Essential Standards of Quality and Safety.	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead	**Work commenced**
	12. The provider and the registered manager failed to effectively assess the complex needs of this cohort of residents to ensure the correct levels of staffing, appropriate training and support were in place. If an effective operating system was in place the same should have identified the risks relating to the health, welfare and safety of the service users	Spreadsheets/ Logs to be developed and held centrally to enable managers to monitor and identify risks and trends to inform changes required to service provision in relation to: (i)Staff recruitment, Induction & ongoing Training, (ii)Referrals and pre admission activity including pre admission	Individuals will be secure in a quality assurance process that identifies shortfalls in service delivery and performance, keeping them healthy and safe Individuals are supported by sufficient numbers of staff, skilled and trained and competent to meet their individual needs. Individuals are supported by sufficient	**30/9/11** Janice Phillips, Registered Manager **9/9/11** Janice Phillips,	**COMPLETED** **COMPLETED**

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
	caused by the lack of proper assessment of the service users needs and the correct staffing levels in order to assess and manage the same	initial risk profile. To also include assessment undertaken in relation to staffing levels required. (iii)Levels and types of incidents including confirmation of those raised under safeguarding (iv)Log of Safeguarding referrals and confirmation/copies of notifications sent to CQC (v) Log of all risks identified and assessments undertaken for staff, service users and the building, showing when reviewed/updated. Logs (iii) & (iv) above to be developed and held centrally to enable managers to monitor and identify trends and risks to service users and enable the service to report incidents appropriately under safeguarding procedures.	numbers of staff, skilled and trained and competent to meet their individual needs. Incidents and risk to individuals are monitored to identify trends and patterns, highlighting areas of concern for reporting and responding to immediately thereby ensuring the safety of the individual is maintained. Levels of incidents experienced by individuals will be reduced. All incidents of abuse/potential abuse experienced by individuals are alerted through the Safeguarding process. All incidents of abuse/potential abuse experienced by individuals are alerted through the Safeguarding process.	Registered manager/ Sue Reilly RMN,Practice Manager, Mental health lead/ Audrey Franks, Operations Manager	

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		Safeguarding competencies to be revisited for all staff to ensure all staff are competent in alerting under safeguarding.	Individuals are supported by sufficient numbers of staff, skilled and trained and competent to meet their individual needs	**9/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead	All permanent staff completed on line training in November 2009 which is repeated within two years. 75% completed on-line training, 50% completed Safeguarding Adults at Risk competencies and 33% completed safeguarding workshops All staff will have refresher training in safeguarding and incident reporting by 30 September 2011.
	13. The registered person had failed to notify the Commission on a number of occasions of multiple incidents where residents had sustained significant injuries as a result of violent behaviour of other people who use the services. If an effective operating system was in place the same should have resulted in an analysis of these incidents in order to make changes to the treatment or care provided where necessary. It should also have identified that the Commission was	Quarterly reporting of all DPS services to be collated and shared with Management Team to identify issues, risks and trends and actions needed to address these within each service. Areas to be included: Falls Medication Incidents Incidents of Violence Listening & Responding Complaints Compliance Information on all the above to be held on Quality Assurance file for each service.	Individuals will benefit from a Quality Assurance Compliance monitoring process that highlights shortfalls in service delivery and performance and areas of improvement to ensure Individuals health, safety and needs are met against each of the outcomes of the Essential Standards of Quality and Safety.	**30/9/11** Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead	**Work commenced**

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
	not being notified				
	14. The registered person and other staff have failed to report multiple incidents of physical and verbal abuse, through established Local Authority safeguarding channels for independent investigation. There was failure to aggregate or analyse the range of issues to identify trends or to take appropriate actions. If an effective operating system was in place the same should have resulted in an analysis of these incidents in to the treatment or care provided where necessary. It should also have identified that safeguarding referrals were not being made.	Revised Quality Assurance/ Compliance visit process to be implemented to monitor effectiveness of all of the above on an ongoing basis	Individuals will benefit from a Quality Assurance Compliance monitoring process that highlights shortfalls in service delivery and performance and areas of improvement to ensure Individuals health, safety and needs are met against each of the outcomes of the Essential Standards of Quality and Safety.	**30/10/11** Management Team/ Shane Heber, Head of Service/ Beverly Scott, Deputy Head of Service/ Steph Arnold & Jacqui Kemp , Admin	**Process completed. To be implemented 1.9.11**
Outcome 16 - other evidence from Compliance Review	Monitoring of service user activities	Activity Monitoring and review to be a clear area within the Quality Assurance Process undertaken by DPS Managers Activities provided to be included in Service	Individuals are involved and contribute to the development and delivery of the service in meeting their activity needs. Individuals are involved and contribute to the	3/8/11 Janice Phillips, Registered manager/ Sue Reilly RMN, Practice Manager, Mental health lead	Revised service user recording will include level of participation of service users and strategies for addressing those who do not get involved in activities. Service uses have individual activity monitoring sheets and these are being monitored monthly. COMPLETED

Outcome 16 Assessing and monitoring the quality of service provision	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		Users Meeting agendas and part of Service User Feedback System to ensure all views are captured to inform improvements in services.	development and delivery of the service in meeting their activity needs.		

Outcome 21

Outcome 21 (Regulation 20) Records	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 **Outcome 21 – Records** **What the outcome says** This is what people who use services should expect. People who use services can be confident that: * Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential. * Other records required to be kept to protect their safety and well being are maintained and held securely where required.	People were at risk from omissions in recording that could impact on the delivery of care, treatment and support Overall we found that Mount Denys was not meeting this essential standard.	Robust file auditing to be undertaken as part of an ongoing process to measure the effectiveness, quality and involvement of the new support plans, risk assessments and guidance. (Links to Actions for all other Outcomes).	Individuals' records will be clear, detailed, appropriate current and contain all the relevant information required for staff to support the individual as they choose to meet their needs.	**30/9/11** Janice Phillips, Registered Manager/ Sue Reilly RMN,Practice Manager, Mental health lead	**Work commenced**
		New working files will contain all information required for staff to have a full understanding of each individuals care; treatment and support needs and how these are meet.	Individuals' records will be clear, detailed, appropriate current and contain all the relevant information required for staff to support the individual as they choose to meet their needs.	**30/9/11** Janice Phillips, Registered Manager/ Sue Reilly RMN,Practice Manager, Mental health lead	**COMPLETED** and quality auditing ongoing
Outcome 21 - other evidence from Compliance Review	Disjointed/fragmentary approach to collation and holding of information	New working files will contain all information required for staff to have a full understanding of each	Individuals' records will be clear, detailed, appropriate current and contain all the relevant information required for	5/8/2011 Sue Reilly RMN, Practice Manager, Mental health lead/Teresa Harrison,	A new system of file has been introduced which collates and holds all information in one place

Outcome 21 (Regulation 20) Records	Detailed failures identified in Compliance Review/Enforcement Notice	Required Action to ensure compliance	Outcome for the individual	Responsible person(s) and date	Progress made in meeting compliance requirements as at
		individuals care; treatment and support needs and how these are meet.	staff to support the individual as they choose to meet their needs.	Practice Manager	COMPLETED

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Recorded Delivery & by Email

East Sussex County Council
County Hall,
St Anne's Crescent
Lewes
East Sussex
BN7 1UE

For the attention of Becky Shaw – Chief Executive

16th September 2011

Reference number: 1-282352321

Dear Madam,

Care Quality Commission
Health and Social Care Act 2008
Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Re: Mount Denys, 187 The Ridge, Hastings, East Sussex, TN34 2AE

We notified you on 1st August 2011 that you were failing to comply with relevant requirements under the Health and Social Care Act 2009 (regulated Activities) Regulations 2010 (The regulated Activities Regulations 2010) as detailed below:

Regulated Activities: Accommodation for persons who require nursing or personal care.

(1) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
It appeared to the Care Quality Commission that you were failing to comply with

Regulation 9(1)(a)(b)(i)(ii)(iii). This states:

9 (1) The Registered person must take proper steps to ensure that each Service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of –
(a) the carrying out of an assessment of the needs of the service user;
and
(b) the planning and delivery of care and, where appropriate,

treatment in such a way as to –
(i) meet the service user's individual needs,
(ii) ensure the welfare and safety of the service user
(iii) reflect, where appropriate, published research evidence and Guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment,

(2) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
It appeared to the Care Quality Commission that you were failing to comply with

Regulation 11(1)(a)(b)(2)(a)(b) (3)(a)(b)(c) (d). This states:

11. (1) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of –

(a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and
(b) responding appropriately to any allegation of abuse.

(2) Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control or restraint being –

(a) unlawful; or

(b) otherwise excessive

(1) For the purposes of paragraph (1), "abuse", in relation to a service user,
means –
(a) sexual abuse;
(b) physical or psychological ill-treatment;
(c) theft, misuse or misappropriation of money or property; or
(d) neglect and acts of omission which cause harm or place at risk of harm

(3) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
It appeared to the Care Quality Commission that you were failing to comply with

Regulation 22, which states:

(22) In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of

carrying on the regulated activity.

During our visit of 18th July 2011 and our subsequent review and analysis of evidence, we identified a range of concerns at Mount Denys in regard to the care and safety of people living at Mount Denys and also the levels of staff available to support their care and ensure their safety. These concerns were the subject of warning notices served on East Sussex County Council.

A further site visit took place on 24th August 2011. As a result of this review of compliance with these warning notices, a management review meeting was held on 2nd September 2011 to review evidence gathered. The outcome of this meeting is that the Commission found sufficient evidence that immediate actions had been taken to improve outcomes for people living in the home to justify the lifting of the three warning notices. Please note that the fourth warning notice against Regulation 10, will be the subject of a separate assessment against compliance.

However, we remain concerned about East Sussex County Council's ability to sustain these newly delivered changes for the longer term, and to permanently embed them in the culture and behaviours of the home. We will be setting compliance actions against Regulations 9, 11, 22, and these will be subject to further review.

If you have any questions about this letter please contact Michele Etherton, Compliance Inspector at the above address and phone number.

Yours sincerely

M J Hansford

Marilyn Hansford
Compliance Manager

Cc. Mr. K. Hinkley - Director of Social Services East Sussex County Council, County Hall, St Anne's Crescent, Lewes, East Sussex, BN7 1UE

Appendix 5 Annex B

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BN7 1UE

For the attention of Becky Shaw – Chief Executive

29th September 2011

Reference number: 1-282352321

Dear Becky,

Care Quality Commission
Health and Social Care Act 2008
Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Re: Mount Denys, 187 The Ridge, Hastings, East Sussex, TN34 2AE

We notified you on 11th August 2011 that you were failing to comply with relevant requirements under the Health and Social Care Act 2009 (regulated Activities) Regulations 2010 (The regulated Activities Regulations 2010) as detailed below:

Regulated Activities: Accommodation for persons who require nursing or personal care.

(1) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
It appeared to the Care Quality Commission that you were failing to comply with

Regulation 10, which states:

10 (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to—
(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.
(2) For the purposes of paragraph (1), the registered person must—
(a) where appropriate, obtain relevant professional advice;
(b) have regard to—
(i) the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to subparagraph (e) and regulation 19,
(ii) any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity,
(iii) the information contained in the records referred to in regulation 20,
(iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)),
(v) reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations,
and
(vi) periodic reviews and special reviews and investigations carried out by the Commission in relation to the provision of health or social care, where such reviews or investigations are relevant to the regulated activity carried on by the service provider;
(c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—
(i)the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and
(ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies;
(d) establish mechanisms for ensuring that—
(i) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person (P), and
(ii) P is subject to an appropriate obligation to answer for a decision made by P, in relation to the provision of care and treatment for a service user, to the person responsible for supervising or managing P in relation to that decision; and
(e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.
(3) The registered person must send to the Commission, when requested to do so, a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (1) are being complied with, together with any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare..

During our visit of 18th July 2011 and our subsequent review and analysis of evidence, we identified a range of concerns at Mount Denys in regard to the care and safety of people living at Mount Denys and also the levels of staff available to support their care and ensure their safety which had not been identified within existing systems of monitoring by the service or by wider monitoring conducted by the local authority. These concerns were the subject of a warning notice served on East Sussex County Council.

A further site visit took place on 12th September 2011. As a result of this review of compliance with this warning notice, a management review meeting was held on 16th September 2011 to review evidence gathered. The outcome of this meeting is that the Commission found sufficient evidence that immediate actions had been taken to improve outcomes for people living in the home to justify the lifting of the warning notice.

However, we remain concerned about East Sussex County Council's ability to sustain these newly delivered changes for the longer term, and to permanently embed them in the culture and behaviours of the home. We will be setting a compliance action against Regulations 10, and this will be subject to further review.

In the acknowledgement of the substantial improvements achieved to date and our confidence that this will be continued bringing Mount Denys to a position of full compliance with the Essential Standards of Quality and Safety in a timely manner I will agree to a lifting of the voluntary ban on admissions with immediate effect. I would be pleased to receive further information and evidence of continuing improvements on a fortnightly basis.

If you have any questions about this letter please contact me either at the above address and phone number or at marilyn.hansford@cqc.org.uk telephone numbers 01622 793735 or 07917210626.

Yours sincerely

Marilyn Hansford
Compliance Manager

Cc. Mr. K. Hinkley - Director of Social Services East Sussex County Council, County Hall, St Anne's Crescent, Lewes, East Sussex, BN7 1UE