Caring Homes Healthcare Group Limited

Oak Manor Nursing Home

Inspection report

Oak Manor
Dereham Road, Scarning
Dereham
Norfolk
NR19 2PG

Tel: 08082235528
Website: www.caringhomes.org

Date of inspection visit:
11 February 2019
12 February 2019

Date of publication:
01 May 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Oak Manor is a residential care home that is registered to provide personal and nursing care for up to 61 people living with dementia or people 65 and over. At the time of the inspection 53 people were living in the home.

People's experience of using this service:
● There were widespread concerns found at the service. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.
●The service was in breach of nine regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
●People were not supported safely. Actions to assess and address risks to people's health, safety, and wellbeing were not always taken.
●People were not protected from abuse and improper treatment.
●Infection control was not well managed.
●The service was not always fully staffed. This impacted on the safety of people in the service and in ensuring people's needs were met.
●There was a negative task focused culture in the home. There were tensions amongst the staff team which impacted on the delivery of the care provided.
●Staff were not always clear regarding their role and responsibilities.
●Quality assurance processes had been ineffective in identifying issues in the home in a timely manner so action could be taken to prevent the service from deteriorating.
●The provider's own audits had identified issues within the home and they had started to take some action to make improvements. At the time of our inspection it was too early to assess how effective these actions would be and if improvements could be made and sustained.
●Training and support for staff was not effective in ensuring good quality care was provided.
●People were not always supported to eat enough and preferences relating to food were not always provided for.
●Staff did not always seek people's consent when supporting them.
●Staff did not always support people in line with best practice guidance and legislation.
●Staff did not work effectively with each other and other professionals to provide effective and high-quality care.

●The environment, including the design of the service, did not meet people's individual needs.
●People were not always treated respectfully and their dignity was not always promoted. People's human rights were not consistently upheld.
●People and relatives were not fully involved in assessing and planning their care. Care was not provided in a way that met people's individual needs and preferences, this included in relation to social activities and interests.
Rating at last inspection: Good (report published 4 November 2017)

Why we inspected: The inspection was brought forward because we received information of risk and concern.

Enforcement: See end of full report for action we told the provider to take.

Follow up: The overall rating for this service is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC.
●Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
●If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.
●For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below	**Inadequate**

Oak Manor Nursing Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
Two inspectors and an expert by experience conducted the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Oak Manor Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The registered manager had left the service and a new manager had been appointed in December 2018 who was applying to become the registered manager. For the purpose of this report, they will be referred to as the manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Notice of inspection: The inspection was unannounced.

What we did: Prior to the inspection we reviewed any notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We used this information to help us plan our inspection.

This inspection included speaking with two people, two relatives, 10 members of staff, an agency staff member, the manager and the regional manager for the provider. We reviewed records related to the care of six people and the medicine records for eight people. We reviewed staff recruitment records for five staff. We looked at records relating to the management of the service, staff training and supervision, staffing levels, maintenance, quality assurance documentation and complaints information. Following the inspection visit we spoke with two health professionals and reviewed further information submitted by the manager.

Inadequate

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Risks to people had not been assessed, monitored or mitigated effectively.
- Staff did not follow guidance to ensure people were kept safe. For example, one staff member was observed feeding a person in a manner that increased the risk of choking.
- On other occasions we observed staff not present or inattentive when there was an increased risk of people displaying challenging behaviour. For example, we observed during the lunch period staff were not always present in the lounge area where a number of people were sitting. We observed one person started to become agitated and tried to remove a cushion another person was sitting on. This led to a verbal disagreement between both people which could have been prevented had staff been present.
- One person had a risk assessment in place which identified potential triggers for episodes of challenging behaviour and how to avoid this. We observed staff did not follow this risk assessment and supported the person in a manner that increased the risk of challenging behaviour.
- Information regarding risks to people was not shared effectively. This meant staff did not always have the correct information regarding how to manage any risks. For example, an agency staff member told us they had not been provided with any information relating to risks to individual people.
- Staff had identified where people were at nutritional risk however sufficient actions were not always taken to mitigate these risks. For example, staff had identified some people needed their weight to be monitored on a weekly basis. This had not consistently taken place.
- Risk assessments were not completed robustly as they did not identify or evaluate associated risks. For example, one person was at risk of falls. Staff had identified this risk and put in place regular observations but other actions and related risks, such as correct footwear or the impact of certain medicines.
- Risk assessments for people at nutritional risk had not been fully evaluated to check if the measures taken to mitigate these risks were effective. For example, some people already on a food charts and enriched calorific meals were still losing weight. Their nutritional risk assessments had not fully evaluated if these measures were effective or what other steps should be taken.
- Staff did not follow good practice guidance in relation to wound management. This meant the associated risks could not be effectively assessed or monitored.
- Staff did not identify or take sufficient action to mitigate the risks from infections. For example, records

showed one person had been agitated for several days and we observed them telling several staff they did not feel well. Staff did not take sufficient action to mitigate the possible spread of infection. We had to intervene to make sure actions were taken and the person was subsequently diagnosed with an infection.
●On another occasion we witnessed staff taking insufficient action when one person was feeling nauseous. This had increased the risk that this illness could be transferred to other people living in the home, staff or visitors.
●Risk assessments in relation to people with infections were generic in nature and not robust. They had not been properly evaluated and follow up actions had not been recorded.
●There was no formal overarching risk assessment and formal plan in place when an increase in infections had occurred and other external professionals had become involved.
●People could not use some areas of the home, such as one of the garden areas or communal activity rooms, because they had been assessed as not being safe and suitable for purpose.
●Areas that had been assessed as not safe and not in use, were locked and access to them gained through a key pad lock. We found the code for this was placed in areas where it could be accessible to others living or visiting the home.
The failure to ensure risks relating to the safety and welfare of people using the service are assessed, monitored, and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●Relatives told us sometimes the service was short staffed. One relative said, "During the week it's mostly not too bad. The weekends there seems to be fewer staff about and yesterday (Sunday) they were definitely a bit short."
●Staff we spoke with told us that whilst staffing levels overall were sufficient the service was often short staffed, particularly at weekends.
●Several staff told us that the weekend prior to our inspection staff had been unable to work at short notice. This had meant the home had been very short staffed.
●Staff told us that it had taken up to lunch time to ensure everyone had breakfast. One person had wanted to leave their bedroom and there had not been enough staff on duty to facilitate this.
●We also found that on a number of occasions externally commissioned 1:1 support to keep a person safe had not been provided and staffing levels had not been sufficient or adjusted to meet this need within the service.
●Staff and health professionals, we spoke with raised concerns about a lack of sufficient nursing staff in relation to the tasks they were expected to undertake.
●Staff were not effectively deployed to ensure people's needs could be met and risks minimised. For example, there was insufficient deployment of staff to provide suitable activities to people in the home.
The failure to ensure sufficient numbers of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
●There were aspects of care within the home that appeared overly restrictive and controlling. For example, we found doors to people's bedrooms were locked preventing them from returning to their room if they wished. One person wanted to show us their bedroom and was unable to do so because this was locked. We noted that this caused the person some distress.
●We observed other people being prevented from moving freely round the home. For example, we observed one person being told to sit down by a staff member when they attempted to leave their chair. A relative told us that their relative preferred to walk around the home but staff took action that prevented them from doing so. We found these actions were not reasonable or proportionate.

The failure to ensure people were safe from improper treatment and abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Risk assessments did not show that risks were effectively evaluated. For example, risk assessment reviews repeated themselves and did not summarise any new risks or if control measures were effective in controlling the risk. It was not always clear how reflective learning following incident and accidents took place. For example, there was no follow up information or outcomes documented when an incident took place.
- The provider had a system to record and analyse accidents and incidents that occurred. However, incident records were not always fully and properly completed to ensure effective analysis. For example, staff were not always accurately or properly documenting episodes of challenging behaviour. This meant these incidents were not being captured within the provider's accident and incident reporting and analysis system.

Using medicines safely

- Medicines were stored safely.
- Medicine administration records were completed accurately.
- Most people's records where they had been prescribed 'as required' medicines had guidance in place for staff on when and how to administer this medicine however we found this was missing for one person.
- Medicines were audited to help ensure they were being managed safely.

Inadequate

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience

- Training and support for staff was not always effective. This was demonstrated from our observations and findings at the time of the inspection. Staff we spoke with raised concerns about the suitability and helpfulness of the training provided. This was particularly in relation to e-learning training. The provider told us some training, such as safeguarding, moving and handling and dementia training was provided via face to face sessions.
- Staff we spoke with did not always have the right knowledge and competence required to undertake their role. In some areas they had not been provided with sufficient training or support. For example, in the provision of activities.
- Staff raised additional issues around the suitability of this training for staff where English was a second language.
- There was an initial competency framework in place for newly qualified and overseas nurses. However, for other nurses, only medicine administration competency checks were carried out. No other competency checks on clinical tasks were carried out. However, no other measures were taken to check if staff required additional support in other areas.
- Training for nurses did not appear sufficient, for example no nurses had received any training in tissue viability. Training was out of date for some nurses and overdue for renewal.
- Health professionals we spoke with raised concerns regarding the suitability and competency of some staff. For example, health professionals raised concerns about the lack of effective support for nursing staff. For example, the lack of specialist leads in areas such as tissue viability.
- There were no champions for certain key areas, such as infection control, to help support the dissemination of best practice guidance and information.

The failure to provide appropriate support, training, and supervision is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff did not always support people sufficiently with their nutritional needs.

●We observed the support offered to people over lunch time and saw people were not always provided with sufficient, or the correct, support to eat.
●For example, one person struggled to eat their meal independently and sat with their meal uneaten in front of them for 15 minutes. This was not identified by staff who later returned and took the meal away from the person without offering any alternatives.
●Staff did not always offer people a choice of what to eat.
●Choices for people were limited. If people were on a restricted diet because of identified choking risks there was only one option. The vegetarian option offered to people was potatoes and vegetables.
●The system in place to ensure kitchen staff had information regarding people's dietary needs and preferences was not effective.
●Staff raised concerns about the length of time it took to ensure people received meals. They said this meant sometimes there was not sufficient time in-between meals.
●We observed people started to receive their lunch time meal at 12pm but the last person was not served till 13:45pm.
●The meal time experience was not pleasant for most people and the atmosphere was poor. Most people sat by themselves. Some people sat near others who had been given their meals, but did not receive their own till some time later. The manager told us they recognised improvements were required regarding people's dining experience and had formulated an action plan to address this, although we did not yet see impact of this at the time of our inspection.
●Some people continued to sit where they had sat for most of the morning and little encouragement was given for people to sit at the dining tables.
The failure to take in to account people's preferences, needs, and provide appropriate support in relation to nutrition is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
●Staff did not always seek consent from people when offering them support.
●People's capacity to make decisions had not always been assessed when needed.
●One person had equipment in place that they found uncomfortable. They asked staff for this to be removed which staff refused to do. Staff had not taken any action to assess the person's capacity to consent to this equipment and to provide the person with adequate information so they could make an informed decision.
●DoLS applications authorised for most people had been renewed when required but we found for one person this had lapsed and a renewal had not been made to legal authorise the restrictions in place.
●Staff had not applied for a DoLs where it was required for a second person.
The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Assessments of people's needs had been carried out. However, these did not always consider the full range of people's needs and were often generic in nature. For example, people were described as having dementia but there was no information about the type, stage or how this impacted the person.
●Staff did not always support people in accordance with best practice guidance and current legislation. For example, in relation to wound management or restrictive practices in the home.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●Staff told us the staff team did not work effectively together to provide good standards of care. One staff member told us, "[The] team is not pulling together, it's all bitty."
●We observed a lack of effective team working which impacted on the support provided. For example, we observed staff not communicating effectively with each other or a person they were assisting to move. This has resulted in the person being unsafe.
●Health professionals told us they felt some improvements could be made regarding the communication and pro-activeness of staff. One health professional said,"[Staff] could be a little more proactive shall we say" in assessing and responding to people's health needs.'
●We observed two occasions where people had informed staff they felt unwell and staff had failed to take effective and timely action in response.
The failure to provide appropriate collaborative support which met people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
●Improvements were required to the design and decoration of the home.
●Some areas of the home had been assessed as not suitable for people and access to these areas had been prevented. This included a music room and a garden courtyard area.
●Some efforts had been made to make areas of the home dementia friendly however these had the potential to be confusing and distressing for some people. For example, a locked boiler room had a sign on it saying it was an air raid shelter. An outside area had signs to make it look as it if was a train station platform. However, this area was out of use and doors accessing it were locked.
●There was a reminiscence room in the home but on both days of our inspection this was locked and not in use.
●We found bedroom doors and doors to bathrooms were locked preventing people from using them.
●There was no appropriate signage on people's bedrooms to help people with dementia identify which room was theirs.
The failure to ensure premises and equipment was appropriate, suitable for purpose, and appropriately located was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Staff were not always respectful and people's dignity was not always supported. For example, we overheard on several occasions staff referring to people by their room number rather than their name.
- There was a lack of thoughtfulness and attention that impacted on people's dignity. For example, one person had been discharged from hospital the day before our visit and were still wearing their hospital tags.
- Staff were not always attentive to people when distressed or unwell. For example, we witnessed one person tell a member of staff they felt unwell and they were distressed. The staff member ignored this person and offered no reassurance.
- Some people appeared unkempt with food around their mouths and down their clothes.
- Health professionals raised concerns regarding the practice of some staff which corresponded with our findings. For example, one health professional told us they had observed staff ignore a person asking for help which had resulted in compromising the person's dignity
- Staff were task focused. This meant we observed interactions were often limited and not always friendly in nature.
- The provider had not ensured people were adequately supported in terms of protecting their rights. This meant people were not always treated respectfully.
- We observed staff did not always explain things clearly to people or allow people sufficient time to respond to them.
- People's independence was not always supported. For example, two people had care plans in place that detailed what actions staff could take at mealtimes to support them to eat independently. We observed staff did not follow this guidance.
- Doors to people's bedrooms and toilets were locked which meant people could not access them independently should they wish to do so.

The failure to ensure people were treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

●People were not always fully supported to make decisions regarding their care. We found incidences where decisions were sometimes made by staff without being fully discussed and involving people. This had been reported on in the 'Safe', 'Effective', and 'Responsive' sections in this report.

●One person we spoke with told us, "Well I used to like to get up quite early, I wouldn't normally be in bed 'til 11 but that's generally when they get me up."

●There was a lack of evidence that people, and those people important to them, were consulted regarding their care. Care plans lacked details and personal preferences.

Requires Improvement

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
●The service did not fully understand people's information and communication needs. Some people had information in place regarding their communication needs but these documents were not detailed and did not provide sufficient guidance for staff.
●Staff did not always present information to people in a way which gave them choice and control. For example, one person had in place health equipment which they did not want to use. Staff told the person this equipment had to be used but did not present sufficient information regarding why. We found there were no care plans in place around the use of this equipment which would have supported staff in these discussions.
●Staff had not ensured they met people's needs and offered choice in relation to people's nutritional and health needs. This has been reported on in the 'Effective' section of this report.
●Staff were not clear on what systems were in place to support people to be involved in planning their support. A resident of the day system was in place, however records showed staff did not always have the time to complete this.
●The resident of the day system was a tick box assessment regarding the completeness of the person's care records. There was no evidence or records to show that it involved discussion and consultation with the person.
●Care plans did not always provide sufficient information regarding people's needs and preferences. Some were generic in nature.
● Activities in the home were lacking and not person centred. A health professional told us there was, "A lack of stimulating time, felt very institutional in that there was this lounge and people sat around it."
●We observed most people sitting in chairs placed around the edges of the communal lounge. Many of whom appeared to be asleep.
●At the time of our inspection the activities time table was out of date and the activities that should have taken place on the first day of inspection did not. On the second day we observed some activities being offered.
●People did not have care plans that detailed how they wanted to spend their time, their hobbies and interests, and how staff could support this.
● Where some information was recorded about people's interests and hobbies, there was no evidence this

was supported or encouraged.

●For example, it had been identified that one person loved music and had enjoyed playing the piano and guitar. During our inspection visits we did not see staff using this information to engage the person. A piano was situated in the dining area, but staff did not encourage the person to use this, and the music room in the home was locked and not in use.

The failure to provide care and support that met people's needs and preferences was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

●People had end of life care and support plans in place. The care plans we reviewed were limited and did not always provide staff with enough information. However, the manager told us that these are updated with further detail at the point end of life care began to be delivered.

●Training records showed staff had not received training in end of life care and support.

Improving care quality in response to complaints or concerns

●The service had not received any recent formal complaints.

●Relatives we spoke with told us when they had raised issues, these had been responded to and they were happy with the outcome.

Inadequate

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Nine regulations of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014 were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- Person centred and high-quality care was not provided in the service. This has been demonstrated in the other domains of this report.
- Prior to our inspection visit we had been contacted by several different sources raising concerns about the standard of care in the home.
- The provider's own audit in December 2018 had identified widespread issues with the quality of care provided.
- There was a task focused culture in the service which had resulted in compromising people's dignity and care.
- There was no clear, effective system in place to promote person centred care and to ensure these were shared positive values within the staff group.
- Staff we spoke with raised concerns about the negative attitude and poor motivation held by other staff. Some staff spoke of bullying within the staff team.
- We observed negative and tense interactions between staff members that impacted on the quality and timeliness of the care provided. For example, we observed one staff member asking another staff member to help them assist a person. We observed this staff member ignoring this request. The first staff member had to ask numerous times from across a communal area.
- Staff were positive about the new manager who had taken up the post in December 2018. They told us the previous manager had appeared stressed and did not always listen to them.

The failure to establish and ensure systems and processes operated effectively to achieve compliance in the service was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had informed relevant people when incidents had occurred in the home.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●Effective systems were not in place to ensure staff understood their roles, responsibilities and accountability.

●Several staff told us the service could be disorganised. One staff member said, "Its completely disorganised. Allocations not completed at beginning of shift so not clear what I am doing. There's no leadership oversight, worst place I have worked."

●There was no clear allocation of tasks. We observed staff deciding amongst themselves what tasks they should do and this resulted in disorganisation, with people not always receiving the care they needed.

●Staff did not work well together as a team and did always appear to understand their responsibilities. For example, some care staff told us understanding safeguarding or MCA was the remit of nursing staff.

● Staff and health professionals told us nurses in the service were overwhelmed, often with tasks that they did not feel appropriate or made the best use of their clinical skills.

●A staff member said, "Nurses are very good, hardworking, I feel they are being pushed to the limit." A health professional said, "Nurses are bombarded all the time."

●A second health professional said, "The infrastructure and processes are not letting the nurses do their job." They went on to say they had observed nurses undertaking tasks, such as organising hospital transport, which they felt was not a good use of their time.

●Quality audits and performance management systems within the home were in place but these had clearly not been effective given the widespread issues found at the time of our inspection.

●It was not clear what systems were in place to provide effective day to day oversight of the care provided and the ability and aptitude of the staff employed.

●There was mixed feedback regarding the visibility of the manager. One person said, "I haven't been introduced so I might have seen her but I wouldn't know." A relative told us, "I think she goes round the home during the day to see people but she does spend much of her time in the office."

●Records were not up to date or accurate. Records were not always stored securely as some records containing people's details were kept out on a table in a communal lounge.

The failure to maintain secure and accurate records, and to establish and ensure systems and processes operated effectively was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider had carried out their own audits in October and December 2018. These had identified many of the concerns identified during our inspection. A home development plan was in place and the provider had started to take action to address the concerns. At the time of our inspection it was too early to assess how effective these actions would be and if improvements could be made and sustained.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

●There were no records that demonstrated people or their relatives had been involved in decisions about their care or the running of the service.

●There had been no recent resident and relatives' meetings for people to provide feedback. The manager told us these had been held in the past but no one had attended.

●There was low morale and tension within the staff team which had the potential to impact on staff's willingness and ability to raise concerns and to speak freely.

●There were no links to the local community.

The failure to establish effective systems and processes to seek and act on feedback from relevant people was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

●Relatives said they had been asked to provide some feedback and information on how to do so was

displayed in the reception area of the home.
●A quality assurance questionnaire had been sent out to people, relatives, and professionals seeking their views on the service in April 2018. We noted people and relatives were largely happy with the service however some professionals had commented on issues regarding leadership and direction, as well as staff competency.

Continuous learning and improving care
●Processes were not in place, or not effective, in supporting continuous learning and improvement
●When incidents occurred in the service there appeared to be a lack of involvement and learning for staff. For example, we saw a debrief should take place for staff when involved in incidents of challenging behaviour for one person. There were no records of any debriefs and the manager could not confirm these took place.
●Incident forms were completed but they lacked evaluation and analysis.
●Staff did not properly document and log incidents that occurred. This meant incidents were not used to support learning and make improvements.
The lack of effective systems and processes to support evaluation and improvement of the service provided was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: People were not provided with care and support that was appropriate, met their needs, and reflected their preferences. People and relevant others were not sufficiently involved and consulted in assessing their needs or in designing the provision of support to meet their needs and preferences. Regulation 9 1 (a) (b) (c) 3 (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: People were not always treated with dignity and respect. Their autonomy and independence was not always supported. Regulation 10 1. 2. (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: The service did not act in accordance with the

MCA. Consent was not always sought.
Regulation 11 1. 3.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Risks relating to the safety and welfare of people were not assessed and mitigated. The premises were not safe for their intended purpose. Staff did not always have the skills and competence required to provide care safely. The risk of infection was not properly assessed or controlled. Regulation 12 1. 2. (a) (b) (c) (d) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Service users were not protected from abuse and improper treatment. Systems and processes were not established and operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: People were not provided with sufficient support and people's preferences and needs relating to food and hydration were not sufficiently provided for. Regulation 14 1. 2. (a) 4. (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment How the regulation was not being met:

Equipment and the premises was not always suitable, properly used or appropriately located.
Regulation 15 1. (c) (d) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The service had not established and ensured systems and processes operated effectively to achieve compliance. This included in relation to assessing monitoring, mitigating and improving the quality and safety of the service and any associated risks. Records were not well maintained or stored securely. Systems were not in place to seek and act on feedback from others or to evaluate and improve their practice. Regulation 17 1. 2. (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified and competent staff were not deployed in order to achieve compliance. Staff did not always receive appropriate support and training to enable them to carry out their duties. Regulation 18 1. 2. (a)