De Vere Care Limited

Oakwood House Residential and Nursing Home

Inspection report

Oakwood House
Stollery Close, Kesgrave
Ipswich
Suffolk
IP5 2GD

Tel: 01473840890

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Oakwood House Residential and Nursing Home is registered to provide care and support for up to 24 people. There were 23 people living in the service on the days of our inspection visit.

People's experience of using this service and what we found
People were not protected in a safe environment. The premises were unclean and were not maintained to a standard which ensured people living at Oakwood House Residential and nursing home were safe. We identified risk in the environment which had not been recognised or addressed by staff or the management.

Medicines were not administered safely. Where medicines needed to be administered at specific times, or with specific gaps between administration, we were not assured that this was done.

The service did not employ sufficient suitably trained and experienced staff to ensure the smooth and effective management of the service. Staff were not up to date with training to ensure they were aware of best practice.

While relatives told us that they believed their relative was safe living at the service, incidents were not always appropriately recorded.

Staff did not always ensure people's privacy and dignity were respected. Staff did not engage with people to ensure they were not socially isolated.

Systems and processes designed to identify shortfalls and to improve the quality of care were not effective. Our two previous inspections have rated the service as Requires Improvement and the service is now rated Inadequate. We are therefore concerned about the overall governance of the service.

Care records did not always provide sufficient detail to guide staff on how to look after people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service support did not support best practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection (and update) The last rating for this service was requires improvement (published 27 February 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service has deteriorated to Inadequate and further breaches of regulation have been identified. The service has been rated as Requires Improvement at the two previous inspections.

Why we inspected

This was a planned inspection based on the previous rating.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring..

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led..

Details are in our safe findings below.

Oakwood House Residential and 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector, a specialist advisor in nursing care and an Expert by Experience. 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
Oakwood House Residential and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager, but they had not yet registered with the Care Quality Commission. Their application to register was in progress. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Both days of this inspection were unannounced.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We sought feedback from the local authority and professionals who work with the home. We used the information the provider sent us in the provider information return.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We observed the care and support provided and the interaction between people and staff throughout our inspection. We spoke with one person who lived in the service and six relatives about their experience of the care provided. We spoke with the provider, the manager and nine members of staff, from the nursing, care and catering teams.

We reviewed a range of records. This included six people's care records and medicines records. We looked at a variety of records relating to the management of the service, including audits, policies and systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed the accident and incident information, nurse's validation and medicine review information we had requested. We received electronic feedback from one relative about the care provided and four professionals about their experience of working with the home.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to properly and safely maintain the environment. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that not enough improvement had been made and the provider was still in breach of regulation 15.

● In the first floor lounge, we saw that the cords to the vertical blinds presented a significant ligature risk. For one blind the cord used to open and close the blind had become detached from the wall and was draped over the back of a chair. This could have caught around a person's neck when using the chair. For two other blinds the cord sagged making a loop which could have been used as a ligature. We asked care staff working on that unit how long the blinds had been in that condition. We received mixed responses varying from the previous weekend, to yesterday. The manager was not aware of the condition of the blinds. The cords presenting a ligature risk were removed by the maintenance person by the end day. On the second day of our inspection visit a contractor was fitting new blinds. However, staff had not recognised the risk over a period of up to three days.
● In a ground floor bathroom, there was rodent control preparation exposed and accessible to people using the bathroom. This was removed when we pointed it out.
● In three en suite bathrooms, we observed holes in the wall where pipes had been boxed in. This allowed access to hot pipes and did not allow effective cleaning.
● In one ensuite bathroom, the light over the mirror was broken and the fitting for the bulb was exposed, presenting a danger to people with a lack of awareness.
● In a ground floor bed room, the handle to an opening window was broken off and lying on the window sill. This meant that the window could not be closed and secured effectively.
● In our previous report of January 2019, we noted that the cupboards in the kitchen areas on the communal lounges were in poor repair with hazard tape used to make repairs. At this inspection, the hazard tape had been removed and some repairs had been made. However, the laminate and varnished handles remained chipped and worn. The chipboard under the laminate was exposed in some areas.
● The provider told us that they planned to start improvement works to the communal areas in September. However, the plans did not include the issues we identified in the en-suite bathrooms and bedrooms.
● Care plans reviewed had a personal evacuation plan for the person, however the master sheet we were given listed two people in the wrong bedrooms. The two people in question had different requirements

which may lead to confusion during an emergency evacuation

Preventing and controlling infection
At our last inspection the provider had failed to adequately manage infection control procedures. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that not enough improvement had been made and the provider was still in breach of regulation 12.

● A relative told us, "The home does need a re-furb, but simple repairs are not carried out like the cupboard door in my husband's toilet is nearly off the hinges, cleaning is not done regularly, the toilet bowl is always dirty, the floor is filthy, I don't think this carpet has been cleaned (vacuumed) since the weekend because all those bits on the floor were there at the weekend, the lampshade is full of dust, that's not a couple of days dirt in the bathroom that has accumulated over a period of time, look at the drain cover it's disgusting, I have complained, and my daughter has, but nothing gets changed really."
● Equipment in the service was not always clean. We observed shower chairs had tears in the fabric, rusty joints and the footplates were soiled. The manager said these were being replaced, however they were still in use at the time of our inspection.
● In one ground floor en-suite bathroom, we saw a brown mark smeared across the toilet seat. A relative told us that the brown mark was faeces and had been there for the past three days.
● The rubber sink plugs in two bathrooms were dirty and cracked. The cracks in the plugs meant they could not be effectively cleaned.
● There was accumulated dirt around the base of taps in en-suites and bathrooms. We pointed this out to the manager on the first day of our inspection and there had been some improvement on the second day.
● There was bread and rolls in a cupboard in one of the communal areas wrapped in cling film. There was no date on the packaging and care staff on duty were not able to tell us how long it had been there.
● Two bins for general waste in communal areas had lids which were broken and staff had to use their hands to open the bin.
● Cleaning schedules did not adequately record what was to be cleaned and how. Since the inspection visit the manager has sent us a revised cleaning schedule which contains more detail and actions for cleaners. However, on the second day of our inspection we went into a bathroom just after it had been cleaned and found stained wipes had been left on the sink by the cleaner. The service was not being effectively cleaned.

Staffing and recruitment
● Insufficient qualified nurses were employed by the service. To ensure night duty was covered with a qualified nurse, the manager was on the rota to cover night shifts. The nurse on duty in the service was responsible for administering the medication to people living in the service. Working as a nurse providing first line care to residents meant that the manager was unable to fulfil their managerial responsibilities.
● On the second day of our inspection the manager was not available due to working the night shift. There was no clear leadership in the service. For example, there was confusion as to what time the daily 'stand-up' meeting was to take place, some staff were told it was cancelled and others that it would take place at a different time. The daily meeting enabled staff to keep up to date with changes and developments relating to individual's care and within the service.
● The nurse working the day shift on the second day of our inspection was unable to attend the stand-up meeting as they were still completing the medication round. They were constantly interrupted during the medicines round due to the need to answer the telephone and queries from staff. Lack of attendance at these meetings by nursing staff meant that care staff may not be brought up to date with clinical issues

affecting people.

Failure to ensure sufficient numbers of suitably qualified staff is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● A relative told us, "His medication is sometimes late, he has Parkinson's and it is very important that he takes them on time, one day I was sat there and the carer came to give him his morning medication and I said to them you're late, she replied we have been very busy this morning, because it was about 11 o'clock and I thought that was late to give him his tablets. When lunch came they brought his lunch meds I said you can't do that he's only just had his morning ones, she replied okay we will save them and bring them back later."

● We observed a nurse administer a medication at lunchtime listed on the Medication Administration Record (MAR) as teatime, no record was made as to why the time had been changed.

● For some medicines such as Parkinson's medicine and anti-biotics, the time the medicine is administered or the gap between when doses is given is important to ensure the medicine is given safely and acts effectively. The service did not record the times that these time critical medicines were given. MAR charts recorded administration as pre-morning, morning, noon, teatime, bedtime. We asked the nurse how they ensured this medicine was given at the appropriate time or with the appropriate time in between doses. They told us that the system did not allow them to do this.

● Not all medicines prescribed to be given 'when required', (PRN) had a related protocol. Where the protocol was in place, it detailed what the drug was used for, when it should be given and the maximum daily dose. More detail should be provided to help staff decide if PRN medication was needed. For example, one protocol stated, 'for constipation', but there was no indication about the person's normal bowel habit so it was not clear how constipation was assessed for that person, to inform staff when this medicine should be given. This meant there was a risk the medicine may either not be given when required or given inappropriately.

● A further concern was a protocol which listed the dose of of a psychotropic medicine as half a tablet. It would be safer to give the actual dose as staff have to cross reference with MAR chart. If the medicine is supplied in a different strength to the one usually dispensed the resident may not receive the right dose.

● Where two PRN drugs were listed for the same indication i.e. 'agitation' it was not clear whether both should be given or whether one should be given first and if or when, the alternative should be given.

● The service kept a separate record of drugs administered PRN as well as a main MAR sheet. Records on the PRN admin sheet did not always tally with administration recorded on the main MAR chart. It was therefore not clear what had been administered.

● Clear protocols regarding the administration of PRN medicines were important as some people living in the service were unable to verbally express when they needed their medicine.

● Daily logs were kept separately from the care plan, this made it difficult to track whether PRN medication had been effective. For example, PRN medication was given for constipation but there was no indication if this had been effective.

● Body maps were used to indicate date and placement of medication patches. However not all records record the removal of the previous patch when a new one was applied. Failure to remove the previous patch may mean the person received an excessive does of the medicine.

● The service was not recording when topical medicines were opened to ensure they were not used after being opened for extended periods.

● Some people were on four or more psychotropic drugs; this is medicine which controls people's behavior and mood. The manager told us that they are aware of this and were being supported to review medication, but it was not clear what the time frame for this is or who had been identified as carrying it out.

● The service was receiving support from the Clinical Commissioning Group with medicines administration. The pharmacist supporting the service told us, "Things have improved from where they were a few months ago and are slowly moving forward."
● The manager carried out regular audits of signature on the MAR charts and where these had not been completed correctly, appropriate action had been taken. However, there was no audit in place which identified the problems we found regarding PRN medicines. been taken.

The service was not safely managing people's medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Covert medication requests were reviewed by the GP and a best interest's decision recorded.
● Medicines were stored safely.

Learning lessons when things go wrong
● Staff did not understand their responsibility to report concerns. We identified two recent issues where staff had not reported the incident correctly.
● In one of these incidents, a person had attempted to clean their teeth with a razor. The risk assessment for the person shaving with a razor, written eight months previously, did not mention the security of the equipment. It had not been updated since the incident.
● The manager told us that they had introduced a system to review safety incidents. However, poor reporting by staff could make this ineffective.

Failure to identify and mitigate risk is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Relatives spoken with told us they believed their relative was safe living in the service.
● Staff spoken with told us they would report any concerns to the senior on duty and knew where to find contact details to report any concerns to the local authority.
● Training records showed that only 14 of 53 eligible staff had received safeguarding training. Lack of training in safeguarding matters meant that staff may not be aware of all the issues they should be reporting.

Inadequate

Is the service effective?

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care was not always delivered effectively. For example, we saw that one person had a catheter in place due to previous urine retention. Their care plan recorded that they had removed their catheter. Nursing staff had contacted the 111 service who had advised that if nobody at the service was able to reinsert the catheter the person should be taken to hospital. There was no further entry in the care plan in relation to the catheter for five days when staff contacted the GP asking whether to re-catheterise the person. Daily notes showed that the person had passed urine as they had a wet pad. However, the person's output had not been monitored to ensure that they did not go into urinary retention following the removal of the catheter. The person's care plan had not been updated to show that they no longer had a catheter in situ.

Failure to identify and mitigate risk is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans relating to supporting people with behaviour that may challenge had insufficient information, or in some cases, no information, about how the behaviour was managed. This resulted in care staff taking inconsistent approaches when people demonstrated behaviour that may challenge. For example, one person who lived with dementia was verbally challenging. They received inconsistent support from different care staff. We observed the person enter the dining room, swearing and verbally abusive. One carer invited the person to sit and talk about what was worrying them. This carer used positive communication skills and distraction. They then put on some music which the person sang along to; this reduced the swearing and distress. Conversely, other care staff told the person off for swearing, saying it was not nice, to stop doing it. There appeared to be no acknowledgment from these staff that the language was a symptom of dementia. Eventually, after being reprimanded three times, the person returned to their bedroom; a few minutes later when this person was taken their lunch they were crying and refused to eat. This put the person at risk of social isolation if staff do not manage their behavioural symptoms effectively.
● The manager told us that a member of staff was re-writing all of the care plans to improve the quality and make them more person centred. However, there was no co-ordinated plan to move from one style of care plan to another. This had resulted in some information not being transferred across.
● People and relatives told us they had not been involved in writing or reviewing the new care plan. The manager told us that they planned to involve people in reviewing care plans when they had been re-written.

Staff support: induction, training, skills and experience
● Our previous two inspection reports had identified concerns with staff completing training considered

mandatory by the service. On both occasions the provider had given assurances that this would be addressed and staff would receive training. However, at this inspection we found that staff did not receive regular training to ensure their knowledge and skills are up to date. For example, records showed that only 14 of 53 eligible staff had received training in infection control. Failure to ensure staff knowledge and skills were up to date could mean that staff could not provide effective care and support.

● The manager told us that new staff carried out three shadow shifts working with a buddy. They received an orientation into the service including fire procedures and documentation. New care staff who did not have a recognised qualification undertook the care certificate.

● Some care staff who had recently started work in the service told us that they were satisfied with the induction they had received. However, other staff told us that they had either not received an induction, or the induction had not given them the information they needed.

● Some staff told us that they had not received updates to their manual handling training. They told us that they received changes to best practice by word of mouth. One member of care staff said, "I would like more training. We used to have a regular trainer but not anymore. We are not always up to date with best practise." We are aware that the provider is in the process of training some senior staff to carry out manual handling training.

● Some staff had not received training which enabled them to support people with their day to day needs. For example, a nurse had received dementia training, but this focused on the bio-medical model and types of dementia rather than communication or care of people with complex needs.

Failure to provide suitably qualified staff is a breach of regulation 18 (Staffing) 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 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 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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisation to deprive a person of their liberty had the appropriate legal authority and were being met.

● The manager told us that nobody living in the service had capacity to make decisions and that everybody either had a DoLS authorised or an application had been made. However, not all care plans contained a mental capacity assessment which supported the DoLS application.

● It was not clear if staff understood the MCA. For example, one person's care plan read, 'Has schizophrenia, would be unable to make informed decisions.' Diagnosis alone cannot be used as an indicator of capacity. The carer responsible for care planning told us they had not received training in mental capacity.

● When we observed medication administration the nurse gave good information to the person about what the medicines were and what they were for. This person declined the medication. The nurse told us that the person had capacity to make this decision, so the medicines were removed and destroyed. There was no capacity assessment in the care plan which showed whether this person was able to make this decision.

● We are aware that a person living in the service had had their picture placed on a web site by the service without their permission, or that of the person's power of attorney. The person with power of attorney had

requested that the picture be removed. Removal had taken over a month to achieve. Due to previous circumstances, this had put the person at risk from others.
● Staff did not always offer people choices in activities of daily living. For example, they did not ask them what they wanted from the lunch menu simply placing a plate of food in front of the person.

Failure to obtain people's consent is a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Care plans contained information about what people liked to eat and drink and their nutritional needs. The manager told us that when they had recently reviewed people's eating and drinking plans and made referrals to the speech and language therapist where necessary.
● Some care plans contained conflicting information about people's eating and drinking needs. For example, one care plan stated in one section that the person needed a fork mashable diet and in another section that they were able to have a normal diet. In another care plan it stated in one section that there was no sign of weight loss and on a normal diet, however, another section stated give fortified foods. There was no indication why fortified foods should be given. Conflicting information for care staff puts people at risk of receiving inappropriate nutrition.
● People were not always asked what they would like to eat or drink. People with communication difficulties were presented with a plate of food, no choices were offered. No condiments were offered.
● People were not always effectively supported to eat their meal. One person was sitting alone and did not touch their food, a carer gave her a spoonful as she passed by. She did not engage with the person tell them what the food was. The care plan recorded the person required assistance to eat.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service ran three systems for recording professional visits. Care staff recorded the attendance of a healthcare professionals in the day file. Some care plans had a sheet for professional visits which give details of the visit. There was also a file in the main office which recorded discussions with family and other professionals. It was not clear how these records were used to support care planning and delivery or how this information was communicated between staff.
● We saw records which showed that a lack of communication at the service had meant that a person had been taken to a hospital appointment which had previously been cancelled by the hospital.
● A family member spoken with did not feel the service had acted promptly enough to ensure their relatives health needs were met. Their relative has been wearing someone else's glasses for several months and they had repeatedly requested both dentist and optician appointments but neither had been made.

Adapting service, design, decoration to meet people's needs
● Our previous inspection in January 2019 had identified that the environment was not managed to ensure it met people's needs. At this inspection we found that some improvements had been made to address our immediate concerns. The provider told us that plans were in place for improvements to the communal areas. However, there were no plans to remedy concerns we have identified in people's bed rooms.
● Relatives raised concerns regarding the cleaning and maintenance of the building.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- The majority of care staff interactions with people were task focused.
- Staff did not always take opportunities to develop positive interactions with people. For example, one person was trying to have a conversation over lunch, the person he was talking to could not respond but the staff supporting with lunch did not respond either.
- Some staff prioritized note keeping over client care. For example, one member of care staff was preparing a person's breakfast, two others were writing notes. A person in the lounge called out but neither went to the person to reassure them when they called out, they just called across the room to tell them their food was coming. This happened four times before the person's breakfast was ready. It may have been helpful if one of the staff had sat with the person so they did not need to shout across the lounge.

Supporting people to express their views and be involved in making decisions about their care
- People were not always supported to express their views and preferences in activities of daily living as far as they were able.
- People had not been involved in writing or reviewing their care plans.

Respecting and promoting people's privacy, dignity and independence
- We observed incidents where staff did not treat people with dgnity. For example, when observing the lunch meal, we saw one person scooping their food up and putting it on the table cloth or on another person's plate. We observed a member of staff supporting people with lunch scoop the food from the tablecloth and place it back onto the first person's plate and walk away. It was not until we questioned this with the member of care staff that they sat and supported the person to eat.
- Language staff used did not always value people. People were referred to by their room number throughout the day by several staff.
- Staff respect for people's privacy and dignity was inconsistent. For example, one person's food was served and then mashed and stirred together in front of them at the table, by a member of staff who was standing over them. However, we also observed staff demonstrating an awareness of people's privacy and dignity. For example, staff supported people to their rooms to discuss health care needs, knocked on bedroom doors, and people were assisted to put on clean clothes after lunch.
- Signs in communal bathrooms directing staff to check people's incontinence pads were not respectful.
- When observing lunch, we saw that everybody was given a drink in a plastic beaker. Care plans did not contain any reference as to why people needed plastic beakers. The blanket use of plastic beakers did not respect people's dignity.

Failure to treat people with dignity and respect is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans prompted care staff to think about ensuring privacy by closing curtains and doors when delivering personal care.
- Care plans were kept securely.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people's needs were not met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Our previous inspection had identified concerns with the lack of involvement of people in their care planning. At this inspection, we found that care plans were being re-written but people had not been involved in the process. The manager told us that previous care plans had been very poor and there was a need to rewrite them quickly. They said they would involve people and relatives when the care plans were reviewed. We are concerned that a lack of involvement in their care planning may mean that care plans were not truly centred on the person, reflecting their current needs and preferences.
- Care plans did not always contain sufficient information to staff as to how people's care and support was provided. For example, there was a lack of information to staff how to support people when they displayed behaviour which challenged.
- Some sections of in people's care plans lacked a title. This made it difficult to navigate and understand what the care plan related to.
- Care plans were in two parts. An abbreviated care plan was kept in a locked cupboard in the service dining rooms. A more detailed care plan was kept in the nurse's station. Some care staff told us that it was not always easy to access the more detailed care plan which gave staff a full picture of the person's care needs. It could also mean that nursing staff were not aware of any concerns recorded in the daily notes by care staff.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- One person's care record recorded their love of gardening. Their care plan stated that they should be supported with walks in the garden. However, their daily notes reflected that they had only been supported to access the garden once in the previous month. Their bedroom did not look out onto the garden but had a view out onto two wooden pallets, some old tyres and a broken green house.
- The service had recently recruited an activities co-ordinator. However, they had not received an induction or training specific to their role.
- Our previous inspection identified that care staff did not engage with people other than when carrying out care tasks. At this inspection, we found that this continued. We did not observe care staff supporting people with any activities of daily living such as laying the table. Neither did we see care staff engaging with people to carry out activities such as jig saws. One member of staff told us that the activities equipment was now locked away in a cupboard and was not easily accessible.
- The activity coordinator had a range of plans to develop the activity programme and increase the resources available. Twiddle muffs and other sensory equipment was available, but people were not consistently offered support to use the resources in the lounge areas.

End of life care and support

● Some care files recorded people's end of life wishes. However, this was not consistent and not all care files demonstrated that this had been discussed with people or their relatives.

Failure to appropriate person centred care which meets people's needs is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a group activity in the ground floor activities area on the first day we visited. It was well facilitated and engaged three people who played musical instruments and sang. Another person repeatedly wandered through and was welcomed. The group provided social and cognitive stimulation for people who attended, and one person was supported by a family member.

● The service supported two people to keep in touch with relatives abroad by video conferencing.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Care plans identified how people communicated either verbally or by body language. However, there was not always a detailed description of the body language used.

● Whether people wore glasses and hearing aids was identified in their care plan.

Improving care quality in response to complaints or concerns

● The service had a complaints policy. On the second day of our inspection the administration officer was responding to a complaint from a relative. We asked to see how this complaint was being managed. Nobody in the service at the time, including the provider, was able to tell us how complaints were monitored and managed. This demonstrated that although there may be a policy in place to manage complaints it was not accessible or understood.

Inadequate

Is the service well-led?

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.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to asses, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Since our last inspection the registered manager had left the service. A new manager had been employed and had applied to the CQC to register. They had been working in the service for four months at the time of this inspection.
- The new manager was making changes to the running of the service. However, they had not engaged with all of the staff team with them and were encountering considerable resistance from within the service. For example, where they had removed posters which did not respect people's dignity staff had replaced them. There was no clear plan from the provider as to how the manager was supported to deal with this issue.
- Some staff told us that they did not feel supported or engaged by the management team. We were given examples of how staff did not feel the provider engaged with them. The manager told us that they had put actions in place, such as giving staff another named person to go to if they had any concerns, but this had not been successful in improving staff morale.
- The provider had not recognised risks in relation to the number of nursing staff employed. When a member of nursing staff had resigned and then called in sick there was no contingency plan in place to ensure the nursing shifts could be covered. This had resulted in the manager needing to cover night shifts to ensure people received the care and support they required. The provider had needed support from the local authority to source agency staff.
- When the manager was not present in the service management roles were not clearly defined which meant staff were not clear as to their responsibilities.

Continuous learning and improving care

- Immediately after our previous inspection the provider had engaged a consultant to support

improvement in the service. However, that consultant left and there was now another organisation supporting the service. This has meant that changes have been inconsistent with little oversight or direction. A health care professional working with the service to make improvements told us, "It has been an uphill struggle what with management and staffing changes."

● Our previous two inspections had identified concerns with the maintenance and cleanliness of the environment particularly with regard to infection control. The provider told us that the areas such as the bathroom and communal areas had been deep cleaned in February 2019. However, at this inspection we again found concerns with infection control and the maintenance of the service. Any improvement made by the deep clean had not been maintained.

● Our previous two inspections had identified concerns with staff not being up to date with training. The provider had assured us after both previous inspections that training would be improved. However, at this inspection staff were still not receiving regular training and updates. This did not demonstrate a commitment to improve and provide staff with the training they required.

● Our previous two inspections had identified that staff did not always engage with people and treat them with dignity and respect. At this inspection we found that this continued.

● Our previous two inspections had rated the service as Requires Improvement in all key lines of enquiry, except well-led which was rated as Inadequate at the last inspection. Despite providing us with action plans as to how the service would be improved, there had been no substantial improvement to the quality of care provided with further breaches of regulation identified at this inspection.

● The provider gave us copies of a variety of audits. However, these audits had not identified all of the concerns we have identified at this inspection. Where the service had identified deficiencies, for example with the recording of medicines, actions taken had not been successful in resolving the matter.

Working in partnership with others

● The manager had put an action plan in place to improve the service and were working with the local authority on this action plan. However, due to the manager needing more support and needing to cover nursing care shifts, some actions in the action plan had been delayed. For example, a staff meeting had been cancelled.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The reporting of accidents and incidents in the service was inconsistent and staff were not always aware of their responsibility to report incidents. We identified two incidents in the service which had not been reported or investigated appropriately. Neither was there any evidence of compliance with the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We received concerns from staff that the senior management team did not engage with them. This had led to staff not feeling valued by the organisation despite the manager putting actions in place to improve staff morale.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care was not person centred.

The enforcement action we took:

Impose a condition to restrict admissions. Notice of Proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not treated with dignity and respect.

The enforcement action we took:

Impose a condition to restrict admissions. Notice of Proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Appropriate consent was not obtained

The enforcement action we took:

Impose a condition to restrict admissions. Notice of Proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There were insufficient suitably qualified staff. Medicines were not managed and administered safely. Risks to people were not identified or managed effectively

The enforcement action we took:

Impose a condition to restrict admissions. Notice of Proposal to remove location

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The service was not managed or maintained to ensure they were safe.

The enforcement action we took:

Impose a condition to restrict admissions. Notice of Proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There are significant shortfalls in the service leadership and the culture in the service did not assure the delivery of high quality care.

The enforcement action we took:

Impose a condition to restrict admissions. Notice of Proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Staff were not suitably qualified or trained

The enforcement action we took:

Impose a condition to restrict admissions. Notice of Proposal to remove location