Care Quality Commission

Northfields Care Homes Limited

Oxford Grange Care Home

Inspection report

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Date of inspection visit: 8, 10 and 12 May 2015
Date of publication: 30/06/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place over three days on 8, 10 and 12 May 2015 and was unannounced.

The last full inspection of this service was completed in June 2013 when we found a lack of compliance in several areas. When we followed this up in December 2013 we found the service had achieved compliance.

The inspection was carried out by 5 adult social care inspectors 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. The expert by experience on this occasion had experience in caring for elderly people, particularly those living with dementia.

Since that time the registered manager has left the service and, at the time of our visit a new manager had been in post for two weeks. This person had not yet applied to the Care Quality Commission for registration.

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.

Summary of findings

Oxford Grange Care Home provides residential care to a maximum of 43 people some who may be living with dementia. Bedrooms are set over three floors with two communal lounges and two dining rooms on the ground floor.

This inspection found a number of breaches of regulations. These are described below.

There were not enough staff available to meet the needs or maintain the safety of the people living at the home and staff recruitment processes were insufficient. People told us they did not feel safe.

There had been a failure to protect people from harm and to recognise and report when people had been put at risk or had been subject to harmful situations.

Procedures in relation to administration of medicines were not safe.

People were at risk from unsafe moving and handling practices and poor standards in relation to infection control and standards of hygiene.

The above demonstrated breaches in regulations 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have the skills, training or support they needed to provide safe and effective care.

People living at the home were subject to restrictive practice which had not been identified or managed in line with the Mental Capacity Act (MCA) 2005 and The Deprivation of Liberty Safeguards (DoLS)

People did not receive nutrition and hydration appropriate to their needs and choices. People had lost weight but this had not been recognised.

People did not have their health care needs met.

The environment had not been adapted in any way to support people living with dementia. There was a lack of appropriate equipment and seating to provide people with safety and comfort.

The above demonstrated breaches in regulations 9, 13, 14, 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were sometimes kindly in their approach but there was a failure to demonstrate an understanding of people's needs for dignity and privacy and respect. Systems in the home did not support people's dignity or well-being. This demonstrated breaches in regulations 10 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive care that was planned or delivered in a person centred manner and people were not given genuine choices in matters that affected them daily.

There was a lack of regard for people's social and recreational needs and a lack of opportunity to engage in meaningful activities.

This demonstrated breaches in regulations 9 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Management of the service was disorganised and chaotic. The manager had been in post for two weeks and there was no evidence of input by the registered provider. Staff lacked leadership and direction. The quality of the service was not monitored to ensure people's well-being and safety. Records relating to care and to the management of the service were inadequate.

This demonstrated breaches in regulations 17 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the concerning nature of some of the observations that the inspectors made during the inspection visits, we deemed it necessary to make safeguarding referrals to the Local Authority for them to be able to investigate this further. Because of these concerns we have continued to liaise closely with both the senior management of the home and our partners to ensure that plans had been put in place to address these concerns.

Summary of findings

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.

There were not enough staff available to meet the needs or maintain the safety of the people living at the home and staff recruitment processes were insufficient. People told us they did not feel safe.

There had been a failure to protect people from harm and to recognise and report when people had been put at risk or had been subject to harmful situations.

Procedures in relation to administration of medicines were not safe.

People were at risk from unsafe moving and handling practices and poor standards in relation to infection control and standards of hygiene.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the skills, training or support they needed to provide safe and effective care.

People living at the home were subject to restrictive practice which had not been identified or managed in line with the Mental Capacity Act (MCA) 2005 and The Deprivation of Liberty Safeguards (DoLS)

People did not receive nutrition and hydration appropriate to their needs and choices. People had lost weight but this had not been recognised.

People did not have their health care needs met.

The environment had not been adapted to support people living with dementia. There was a lack of appropriate equipment and seating to provide people with safety and comfort.

Is the service caring?

Inadequate

The service was not caring

Staff repeatedly failed to demonstrate an understanding of people's needs for, privacy and respect.

Systems in the home did not support people's dignity or well-being.

Is the service responsive?

Inadequate

The service was not responsive .

People did not receive care that was planned or delivered in a person centred manner and people were not given genuine choices in matters that affected them daily.

There was a lack of regard for people's social and recreational needs and a lack of opportunity to engage in meaningful activities.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

Management of the service was disorganised and chaotic.

Staff lacked leadership and direction.

The quality of the service was not monitored to ensure people's well-being and safety.

Records relating to care and to the management of the service were inadequate.

Oxford Grange Care Home

Detailed findings

Background to this inspection

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

This inspection took place over three days on 8, 10 and 12 May 2015 and was unannounced.

The inspection was carried out by 5 adult social care inspectors 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. The expert by experience on this occasion had experience in caring for elderly people, particularly those living with dementia.

As part of the inspection process we looked at all the information we hold about Oxford Grange Care Home. This included the notifications of events such as accidents and incidents sent to us by the home and reports from local authority contracts visits including infection control. On this occasion we had not sent a provider information return (PIR) to the provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection the Care Quality Commission had received concerns about the care and welfare of the people living at the home and insufficient staffing.

During visits we spoke with 31 people who lived at the home, and 13 members of staff including the manager. We also spoke with three members of agency staff working at the home. We looked around the home, observed practice and looked at records. This included 18 people's care records, two staff recruitment records and records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We made two SOFI observations where we followed the care of seven people over the periods of one hour and forty minutes respectively.

Inadequate

Is the service safe?

Our findings

During our visit we spoke with people who lived at the home about what they thought made the home safe. We asked people if they felt safe, if they thought there were enough staff and if the home was clean.

These are some of the things people told us about their feelings of safety in the home: "Not everyone gets on with each other but it's not so bad", "I feel safe, it's just a general feeling" Others were much less positive. One person said a man who lived at the home frequently came to their bedroom door and this made them feel frightened as the person usually had their trousers undone. They told us: "I'd throw a bucket of water over them if I could". Another person said they sometimes felt afraid they might fall if they used the toilet and there were no staff around. One person told us they were afraid and thought staff handled them roughly. We asked this person if they felt safe living in the home and they said: "No love, I don't feel safe at all here".

When we talked to people about staffing in the home they said. "Sometimes staff aren't easy to find. I don't think there are enough to help the people that need help" and "They never have time to help me." A visitor told us "There are enough but they're so busy." When we spoke with their relation about how they would find someone to tell them they needed assistance they said they did not know. The visitor told us there were often times when staff were not present in the communal rooms.

All the staff we spoke with commented that there were not enough staff in the home. A number of staff were visibly upset by this and one said they wanted to spend more time with people who lived at the home but they were not able to do this because they were so busy with care tasks. Another member of staff told us they knew mistakes were sometimes made due to low staff numbers, because staff were constantly being "pulled in all directions".

On all of the three days of our inspection the manager told us there were issues within the home that affected people's safety. They gave examples of unsafe systems for administration of medicines, unsafe and potentially dangerous safety rails on people's beds, insufficient staff numbers and a lack of staff competence. We looked into all of these issues.

On the first day of our inspection the manager told us care staffing was arranged at one team leader and five care assistants during the morning, one team leader and three care assistants during the afternoon and one team leader and two care assistants during the night. In addition an activities coordinator was on duty four hours a day on weekdays.

We looked at the staff rota for the week prior to our inspection and saw that this did not always reflect the staffing levels the manager had described to us. For example on six days there had been a team leader with only four care assistants on duty in the mornings.

At the end of our visit on the first day of inspection we told the provider that, due to our observations of there not being enough staff to meet people's needs, staffing levels must be increased immediately.

On day two of our visit we arrived at the home at 4pm. There was one team leader in charge with five care assistants, four who were agency staff and for one it was their first shift since a three day induction the previous week. This meant only the team leader knew people and their individual needs. On day three of the inspection we arrived at the home at 7am. We saw there were four staff just completing the night shift. These were two regular staff, a new member of staff on their first shift and a member of agency staff. The member of staff on their first shift had not received any induction and therefore could not legitimately be counted within the numbers. Staff were unable to tell us how long people had been up and who had assisted them. The team leader did not know the names of the agency staff. We spoke with the member of agency staff who said they had never been to the home before and was just finishing their first night shift duties.

Over the three days of our inspection we observed numerous examples of where inadequate staffing had a significant impact upon people's care and safety and we had to intervene on several occasions to make sure people were safe and their needs were met. For example, on arrival on our first day we saw there were nine people in the lounge and dining room and there were no staff in sight. We saw a man who lived at the home displaying sexual behaviour in front of two ladies. We immediately tried to locate staff but were only able to find the activities coordinator who assisted in finding a member of care staff. On the second day of our inspection we observed one person calling out repeatedly "Please come and help me it really hurts." We saw this person used a medical appliance which needed frequent attention but clearly had not been

Inadequate

Is the service safe?

attended to which was why the person was in pain. We attempted to find staff to assist this person but were unable to do so. We intervened to ease some of the pain the person was experiencing and went to find staff again. When we did, a member of staff said to the person "We'll be with you in five minutes." Again we had to intervene and insist that staff supported the person immediately.

On all three days of our inspection we observed people in states of distress because they had not been supported with their continence needs. On the first day of our visit we saw people who were not independently mobile did not leave their seats at all during the eight hours of our visit. This meant they did not have their continence needs met. When we asked staff about this they said they hadn't had time to assist these people to the toilet. On the second day the team leader told us that people had been assisted to the toilet just before we arrived, however a member of agency staff told us this had not happened. We observed staff telling people they would have to wait for attention, when one person said they would like to go to bed, we heard staff tell them: "You'll have to wait; we are doing people in order".

On the third day of our inspection we saw half hourly check records had been completed for two people assessed as being at risk. We looked at the record for one of the people dated 8 May (the first day of our visit) and saw this was not correctly completed. We knew this because we had case tracked this person and recorded their whereabouts in our inspection notes. The half hour check document was different so we spoke with the person who had been team leader on that day. They told us the checklist had not been signed by them, but by another member of staff and was falsely completed. They said "how can we possibly have time to do these checks, you saw how busy we were on Friday and you know we did not make any checks. These records are not true".

When we spoke with the manager about this they said they knew the staffing levels were insufficient to meet people's needs. They said they were aware people were being ignored and neglected because of this. They said they knew people's continence needs were not being met, people who needed to go to bed were unable to do so and people were left unattended in their chairs when they clearly indicated they were uncomfortable.

We looked at recruitment files for two members of staff. The files contained an application form and references. A note on the application form confirmed that a Disclosure and Barring Service (DBS) check had been made before the staff had started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. However we found that some of the references were not dated or signed and could not be authenticated. There was no reference to any probationary or induction period. One of the staff we spoke with told it was their first shift and they had not had any induction or shadowing shifts. This person was counted in the staff numbers for that shift.

This meant the provider had failed to make sure there were adequate numbers of appropriately trained staff on duty to maintain the safety of people living at the home. This is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection, we asked the manager if they had raised the concerns they had described to us about poor and unsafe care with the local authority safeguarding team. They told us they had not. We asked the manager to make a whole service safeguarding alert immediately.

We found that staff did not recognise when people were at risk or what might constitute a safeguarding concern. For example, when we spoke with staff about the man who had displayed sexual behaviour in front of two ladies, they lacked awareness that it was a safeguarding concern; there was no consideration for the people who had witnessed this and staff nonchalantly remarked that this behaviour was not unusual for the person. This was not recorded as a safeguarding incident. Staff we spoke with were able to tell us about some possible signs of abuse. However, in practise, our observations found they lacked insight into what constituted abuse and, in particular, there appeared to be a lack of understanding of neglect. Three of the staff we spoke with could not tell us whether there was a safeguarding policy in place. Additionally, staff showed a lack of understanding of whistleblowing and they were not aware of what to do, or whether a policy existed to refer to, if they witnessed or heard about staff conduct that may cause harm to people or put people at risk.

Inadequate

Is the service safe?

This meant the provider had failed to maintain the safety of people living at the home. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the third day of our inspection we asked the manager to make a further 10 individual safeguarding alerts in respect of individuals who were at risk. We also made an individual alert.

Staff told us about their concerns in relation to how they might evacuate people from the home in an emergency. They told us about one person whose bedroom was on the second floor who they felt they would struggle to assist. We noted that the fire evacuation plan gave the instruction that 'any resident who is bedridden and too heavy to move may be tied to a mattress and dragged out to safety.' We referred our concerns relating to people's safety in this regard to the fire authority.

We found people were at risk due to very poor standards in relation to cleanliness and infection control. We found some people's mattresses heavily soiled and mal odorous. Bed linen on some of the beds we looked at was dirty and stained. On the third day of our inspection the manager showed us a photograph they had taken on a telephone of some very heavily soiled sheets which had been left unchanged when the person went to bed. We saw soiled carpets and furniture throughout the home. Hand washing facilities were not available as required and toilet and bathrooms were unclean. We saw the crockery and plastic cups in use were cracked, chipped and heavily stained.

We noticed a member of staff had a hair comb in their pocket. We asked what this was for. They said they used it for the people who lived at the home because they didn't have their own. Communal use of combs can present an infection control issue and shows little regard for people's dignity.

An inspection carried out by the local authority's infection prevention nurse on the third day of our inspection concluded that standards in the home were extremely poor.

On the first day of our visit, the manager told us that bedrails were in place on some beds which were dangerous and presented significant risk of entrapment to the people using them. We found this to be the case. When we looked at risk assessments for these bedrails we saw that staff had recorded them to be safe. We also saw that daily checks of bedrail safety had been recorded. We noted these had been signed by the deputy manager each day. When we asked the deputy manager how they had done this, even on their days off, they told us they had done them retrospectively. This meant that the records had been falsified. We asked the manager why they had not removed the bedrails and employed alternative measures to promote the safety of people at risk of rolling out of bed. The manager told us they were awaiting the delivery of new profiling beds which included safe bedrails. These beds were not delivered until the third day of our inspection and the unsafe bedrails had remained in place in the interim five days.

We found that accidents and incidents had not always been recorded accurately. There was no monitoring of accidents and incidents and the records we found were not completed or filed appropriately. This meant that service had no means of reviewing the safety of people at risk of accidents at the home because of this lack of monitoring.

Over the three days of our inspection we witnessed a number of unsafe moving and handling procedures. For example, we saw two staff attempting to assist a person from their wheelchair into an armchair; and no equipment was used. They pulled on the person's arms to bring them from their wheelchair, whilst instructing the person to 'stand for me, stand up'. Staff commented to one another that the person's legs were 'in a tangle'. We saw the person struggled to bear their own weight and was leaning heavily into staff. We intervened and asked the member of staff whether the person had any moving and handling equipment as this was an unsafe situation. The member of staff said "I dunno really, I'm not usually on cares, I'm usually team leader". Another example was when four staff tried to assist a person with the standing hoist. This type of hoist requires the person to be able to bear their weight. On this occasion the person was not bearing any weight but staff continued to use the hoist resulting in the person moaning in pain and grimacing. We intervened to stop this procedure. Staff then went to bring the full hoist. When they returned with it they found the battery was not charged. They replaced the battery with the one from the standing hoist and then tried to work out how to fit what they thought was a hoist sling. This was identified by the inspector as a slide sheet which is a piece of equipment

used to support people to move in bed and not associated with the hoist equipment. We also saw staff perform drag lifts. This kind of manoeuvre is unsafe and can cause pain to the person and injury to staff.

We saw one person being assisted to the dining room, by two members of staff who were holding the person under their arms with the person between them. We observed staff walked much quicker than the person was able to as they had difficulty moving their legs and these became twisted. This resulted in the person being dragged across the room.

We saw staff did not know which walking frame was for which person; there was no indication on the walking frames or who they belonged to. We saw one frame used for one person who was tall yet they had to bend over to use this. The same frame was then passed to another person who was smaller in stature. Staff told us they did not know which equipment was for which person.

The manager confirmed to us that staff did not know how to move people safely and did not know how to use equipment. We asked the manager to raise safeguarding alerts for four people who we believed to be at immediate risk from unsafe moving and handling manoeuvres. This was done.

The manager told us that systems for the administration of medicine were unsafe. We saw that medicines were administered by team leaders who wore tabards informing people they were administering medicines and should not be disturbed. On the first day of our inspection we saw the team leader's medication round was interrupted four times in a 15 minute period; when we asked about this we were told this typically happened and medication rounds were frequently interrupted because there were not enough staff available to people. We witnessed a similar situation on the second day of our inspection. On the third day we saw that the morning medication round was not completed until 12.15pm. We asked the team leader if there was anybody who needed their medicine at a certain time. They told us there wasn't. However when we checked we saw that one person was taking a medicine for which the timing of administration was critical to the therapeutic effect of the medicine. At 11.45 am we asked the team leader what time the person had taken the medicine prescribed to be given at 9am as the person's MAR (Medication Administration Record) did not show it had been administered. The team leader said "Oh ages ago, I just forgot to sign for it." We asked what time the person would be administered the dose prescribed for 1pm. The team leader said "They should have it at 1 but I have my dinner then so it will probably be about 2ish."

When we pointed out that the medicine should be taken at the prescribed times the team leader told us they did not know this. We saw the lunchtime medicine round was started approximately an hour after the morning round had been completed. Administration of lunchtime medicines was still in progress at 2.45pm. Times of administration were not recorded. This meant that people could have received their medicines, prescribed to be given at four hourly intervals, either too close together or too far apart in terms of time. This may have an adverse effect on the person.

We saw one person who, according to their care plan, suffered from a painful condition and was to be given pain relief medication before being assisted to move. We saw this person was offered no pain relief before staff assisted them to move.

On the first day of our visit we saw a GP visit and give a prescription for antibiotics for a person who presented as unwell. When we made our second visit two days later we saw that this prescription had not been obtained. On our third visit we saw that the person had started this medicine three days after it had been prescribed. Another person who presented as ill and in great discomfort had been prescribed antibiotics and other urgent medicine by the GP on the first day of our visit. This person did not receive this medicine until two days after it was originally prescribed.

We checked a number of people's medicines and found that those dispensed by the chemist in dosette boxes tallied with the amounts recorded as received and administered. However we found this was not the case for all of the medicines dispensed in boxes, particularly those for PRN (as required) administration. Amounts of these medicines had not been recorded on the MAR and in four of the five we checked, the amount of medicine still available in the box did not tally with the amounts recorded as having been administered.

This meant the provider had failed to ensure the safe care and treatment of people living at the home. This is a breach of regulation 12(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

During our visit we spoke with people who lived at the home about how staff looked after them. People said "I think the staff know what they are doing," but could not tell us what sort of things the staff did that informed this belief. Another person said "I don't think the staff know me, they haven't sat and got to know me." One visitor said they had no concerns about practice at the home whilst another told us staff did not always support their relative in the way they had requested. Another relative, who raised direct concerns with us prior to the inspection, told us they were not happy with the way staff had supported their relative and did not feel they had managed an incident well. They also told us staff had told them medical assistance had been sought for their relative when it had not.

We asked people about the food served in the home and they gave responses such as "nice" and "good" but could not tell us about how their needs and tastes were catered for. One person said "We do get nice food. We get a choice." We asked about availability of drinks and snacks. One person said "We can't have anything to eat between meals. We get drinks sometimes. I'm not sure how I would get a drink if I wanted one."

The manager told us that staff did not have the training and support they needed to do their job effectively. When we spoke with staff they made comments regarding their lack of direction and said they were not sure of their roles and responsibilities and what tasks should take priority. Staff said they did not receive regular supervision and one said they could not remember the last time they had received it.

We looked at personnel files for two recently appointed staff. Neither file contained any detail of induction. We spoke to one of these members of staff who confirmed they had not received an induction.

We looked at the staff training matrix which indicated that the majority of staff were up to date with mandatory training such as fire safety, moving and handling and infection control. We did not see any information about the content of the training staff had received and for many areas there was no record of who had provided the training. Areas such as infection control, safeguarding and dementia care were recorded as being provided 'in house'. We saw over half of the care staff had achieved NVQ level 2 qualification in care with nine having also achieved level 3.

However we saw little evidence of staff putting any training they may have received into practice. For example we saw several examples of staff not following safe moving and handling practice, staff failed to recognise safeguarding and staff failed to meet the basic needs of the people living at the home.

This meant the provider had failed to make sure that staff received the appropriate support and training they needed to enable them to carry out the duties they are employed to perform. This is a breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw many examples of how people's rights to liberty were not respected and promoted. For example, doors were locked and people who asked to go through them were discouraged by staff. We saw one person who could not clearly communicate verbally, showed many outward signs of wishing to move from their chair. The person's chair was pulled up to the table and they made intermittent attempts to move themselves, without success. The person looked anxiously round the dining room for staff, but no staff were available to assist. The person looked uncomfortable and we were aware through our observations they had been in the same chair for five hours with no staff intervention for personal care. We pointed this out to the manager, who agreed the person's liberty was being restricted and she asked staff to assist the person.

During the afternoon we saw a gathering of people outside a store cupboard and one person told us: "It's cig time". When we questioned this we were told people who smoked could only have cigarettes at designated times during the day and all at the same time. One person said: "I'd love a smoke when I want one, but you can't in here. If it's not time you have to wait". Another person said: "It's just tough, you can't have one and that's that". Staff told us they could only supervise people to smoke when there were enough staff available and they tried to keep to set times during the day for this reason.

Inadequate

Is the service effective?

On one occasion a person who lived at the home called out to us saying excitedly, "The garden door is open, can I go out?" We asked the person if they could go into the garden when they wished, they said they couldn't. We had seen that the garden provided a safe area and asked a team leader why people didn't have access to it at all times. The team leader told us they opened the door when it was nice weather. When we challenged this saying different people enjoyed different types of weather, the team leader said "Oh yes, I never thought of that." This demonstrated that staff had not considered people's right to access the outdoors whenever they chose.

We saw that only two people who lived at the home had a key for their bedroom door. None of the other people were able to access their rooms without asking a member of staff.

There was a lack of understanding amongst staff we spoke with of the concept of capacity and how staff would know if a person lacked capacity. One staff member said they thought it was "something to do with independence". We did not see any evidence of proper assessments of people's mental capacity. Staff said people could not leave the home unaccompanied because the external doors were kept locked. They would try to distract a person if they tried to leave. Staff could not demonstrate an understanding of restraint without being prompted. There was no understanding of what constituted a deprivation of liberty and how this might be safeguarded, although one staff member thought they had received training in this area.

When we spoke with the manager about this they said the home was "Like a prison." They told us that the provider "did not believe in DoLS" and that was why none had been applied for. They told us they had recognised an urgent need to address this issue.

This meant the provider had failed to make sure that people who lived at the home were not deprived of their liberty without lawful authority. This is a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed four meal times during our inspection. This included two lunch times, a breakfast and a tea time meal.

At lunchtime in one of the dining rooms, people were presented with their meals on plates put in front of them with no consultation about portion size or whether they wanted the meal or any of its component parts. There were no condiments on the dining tables for people to season the food to their own tastes and one person asked staff four times for some salt before they could have any. The menu choices for the day were either fish or fish pie, which was limiting for those people who did not want a fish meal. One person's care records stated they did not like fish, yet they were served fish pie.

We saw people were not properly supported to eat their meals. For example, one person's care records showed they had poor eyesight and required staff to prompt them with eating. This person was given their meal in the lounge and the table used was too far away for them to reach. When the person attempted to pull the table closer the plate slid into their lap and the inspector had to intervene to ensure there was no spillage and the person could reach their food properly. When prompted, staff repositioned the person's table and brought a cushion for the person to sit more comfortably. People who sat to the tables in their wheelchairs were seated too low and their chin was close to their plate of food. Some people on dining chairs were positioned too far away from the table to reach their meals.

In another dining room we saw people were seated at tables from 12.00 to 12.15 before being offered a drink. During this time two people exchanged views on not having anything to drink. Plastic beakers were then put on the tables before people were offered a choice between "Orange or lemon?" with no further comment.

The meal was not served until 12.30. One person said "I wish they would hurry up." Another person asked "Have they been round with the list of what we can have?" There was no music or other stimulus to create an atmosphere and people did not engage in much conversation with each other. Staff only came into the room in this time period to perform tasks and did not engage in conversation with people.

When food was served it was brought from the corridor ready plated. Several people were served their meal and told "Fish, chips and mushy peas," with no further comment.

When people appeared to have stopped eating the staff member present asked "Are you finished, lovey?" before clearing the plate away. No one was asked if they wanted any more or if they had enjoyed their meal. The staff

member expressed no concern when they cleared one person's plate although they had eaten very little of their meal. This meant that staff demonstrated little understanding of the need for adequate nutrition.

We saw that one person who had said they didn't like fish and had been told by staff they could have eggs instead, was served fish and chips. By the time the eggs arrived the person had eaten the fish and chips.

When one person tried to help themselves to some more juice the staff member asked "What are you doing?" and indicated that they should sit down. Later in the meal the same person left their seat and went to ask if they could have a pudding that was spare. The staff member did not acknowledge them but when the person repeated their request staff said "Sit at the table."

On the second day of our inspection we saw people were served 'buffet' tea. This consisted of two small triangles of sandwich, a small open sandwich, two small sausage rolls and one piece of tomato. People were not given any choice in this. We saw one person push it away saying to the agency member of staff "I can't have this, I don't have any money to pay for it." The staff member ignored the person who then became distressed and said to us "I haven't touched it because I can't pay for it." The staff member had left the room so we offered reassurance to the person. They continued to appear distressed and said "I don't like sandwiches so I'll just eat a little bit."

People were not offered a drink in this room until they had finished their sandwiches and several people were not provided with any desert.

We saw a member of agency staff support a person to eat a small bowl of soup. The staff member told us the person needed a liquidised diet. They also assisted the person to drink half a plastic mug of tea. When we later looked at this person's fluid intake chart we saw that another member of staff had recorded the person had taken 200mls of tea and 350mls of juice in the time we had been observing them. We knew this was incorrect from our own observations. Another member of staff later told us this person did not require a liquidised diet. This meant the person did not receive appropriate nutrition or hydration in line with their needs.

On day three of our inspection we saw people were presented with their breakfast with little consultation and where people were asked what they would like staff did not provide them with their choices. We saw one person bombarded with questions from staff such as 'what would you like?' 'What do you want, cooked breakfast? Cereal? Nothing?' The person did not have time to process the information. When staff asked again if they would like a cooked breakfast the person smiled and nodded, indicating they would. Staff brought them a bowl of cereal, which was not what they had indicated, and put this down in front of the person. The member of staff then put a plastic apron over the person's head without any discussion, and walked away. We saw another person served toast and jam. The person became very angry saying "I've told them I don't like (expletive) jam but they don't care, I just won't bother with anything." We asked the person what they would like and they told us fruit and porridge. We informed staff of this but the person was given toast and marmalade. Another person ate very little of their toast, when we looked, we saw the toast was burned.

We saw one person who had been assessed by the Speech and language therapist (SALT) as being at risk of choking. The recorded SALT advice was that the person must be supervised when eating. We observed this person had their meal served in their room without any staff supervision and on another occasion was left without any staff supervision whilst eating in the dining room.

On the third day of our inspection we saw three people who needed support to eat were served their meal without any staff being available to assist them. The food appeared cold by the time staff arrived to support them. We saw one person was very sleepy, they were offered two mouthfuls which they ate but then said they 'wanted a minute.' Staff did not return to support this person further.

We saw from care records that a number of people had lost weight. However when we looked at care records and assessments related to weight loss we found they were incorrect. For example, one person who had lost 4kg since February 2015 had a nutritional risk score of zero. This included a score of zero for the question about weight loss in the nutritional risk assessment screening tool.

We looked at the fluid intake charts for a person who had recently been in hospital with serious infections. We saw that the total daily fluids recorded as taken by this person were recorded on the chart as insufficient to meet the needs of the person. On the second day of our inspection we observed this person to be given only 50mls of fluid in a two hour time period and the member of agency staff

supporting this person told us that was all they would take. However when we looked at the fluid chart for that time period we saw that 750mls of fluid had been recorded as taken by this person. We knew this to be incorrect.

This meant the provider had failed to make sure that the nutritional and hydration needs of the people living at the home were met. This is a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from the home's own information and the manager confirmed to us that Oxford Grange provided care for people living with dementia. However we saw no evidence of any adaptations to the environment which would assist people living with dementia. Staff failed to respond to people who were confused or anxious due to their confusion. We saw a lot of people spent their time walking with purpose, although there were no destinations such as places to sit, or items to encounter as they walked around for people to engage with.

We did not find anything in care plans to instruct staff in how to support people to live well within their dementia. For example for one person who had been identified as living with dementia, the social activity was 'Staff to observe (name) when (they are) walking around the home.' The intervention for this persons confusion was for '1 x staff to communicate with (name) on a daily basis.'

Another person's records in relation to their mental state said 'Staff to reassure (name) when they become upset and weepy.' There was no instruction about how to reassure this person and we witnessed several occasions when staff ignored them when they were upset. On one occasion we had to intervene when staff failed to support this person when they were afraid to enter their room and wanted somebody to check it for them. This meant that staff had failed to recognise the person's anxiety or offer them reassurance.

We witnessed several instances of people not having their health care needs met. For example, we witnessed people who needed to use pressure relieving cushions, were not provided with them. In some cases this was for several hours. For example on the second day of our inspection we saw a person assessed as in need of a pressure relieving cushion seated on a dining chair with no pressure relief at 4pm when we arrived and was still there at 5.40pm. We asked a member of agency staff what they knew about this person. They replied: "I'm sorry I don't know what they need". At 7pm this person was still seated on a dining chair and we brought this to the attention of the manager and asked her to take action. On the third day of our inspection we saw this person was still not seated on a pressure cushion when we arrived at 7am. By 11am the person was still not seated on a pressure cushion and we went to speak with the manager about this. They told us: "I know, there should be a pressure cushion for this person. There isn't one. There aren't enough pressure cushions for everyone. I have made a referral to the district nurse". We saw no immediate action was taken to support the person.

On the first day of our inspection we had concerns about one person who appeared ill; they made grimacing facial expressions that suggested they may be in pain interspersed with sleeping in their chair. This person was very pale and one member of staff who walked past commented 'you look a bit pale' yet did not take any further action. We brought our concerns to the team leader who said this person was 'always like that'. When we saw this person refused their meal and drinks we raised our concerns again with the manager and said we thought they needed to see their GP. The manager agreed the person appeared ill and contacted their GP. This person remained in their chair, despite sitting in an awkward position and when we suggested to staff they may be more comfortable in bed, we were told there were not enough staff to do this. When the GP visited this person we saw they were unable to examine them as the person was still sitting in the lounge and was resisting the rushed efforts of staff to assist them to their room. We observed that staff were vague in their descriptions to the GP about how the person had presented. On the third day of our inspection, we saw that the medicine prescribed by the doctor for this person had not been obtained until three days after the prescription had been made. When we looked in this person's care records we saw there was no record of the GP visit, what they had prescribed or how the person had been.

We had further concerns about one person who was clearly uncomfortable and was scratching their skin. We saw they had a very red inflamed rash; we asked staff about this and they said they were unsure what it was. Staff said they 'thought' the person had some cream for this, although could not clearly state what the cream was other than to say they 'assumed' the information would be in the person's care records. We looked in the person's care records and there was some reference to the person's

needs, but nothing about this particular health concern. On the second day of our inspection we saw this person was still scratching their skin. We saw their care records showed they should only have unscented toiletries/ bath products. We saw in their room there were unscented toiletries but also a bottle of strong scented body wash and soap. Staff told us they would only use the unscented products. On the third day of our inspection we saw this person assisted downstairs; they held out their hand to the inspector and we noticed they smelled very freshly scented. The carer stated: 'You've had a lovely wash with [scented product] haven't you?'

On the third day of our inspection we saw a person sitting in the lounge suffering from a heavy productive cough and struggling to breathe. This person told us they felt "really poorly." We saw that the GP had seen this person three days previously and had prescribed medication. This medication was not obtained and administered until two days later. The manager looked into this and said they could not understand why there had been a delay. When we spoke to the person they said they wanted to put a cloth over their head and breathe in some steam. The person was not supported to do this. We saw a member of staff ask the person to go to the dining room for lunch. The person said "Do you really think that would be fair on other people with this cough?" The carer said "Oh are you not well" and walked away.

We saw one person who had been provided with some specially made medical appliances to assist them. They had obtained the appliances the day before our visit. We saw the instruction from the hospital was for them to be used for two hours a day for the first week. We saw this person still using these for over five hours and brought it to the attention of the manager who asked staff to remove them.

On the third day of our visit we saw one person with a very bruised arm and noted they did not look well. We asked the deputy manager if this person was to be seen by the doctor. The deputy manager told us they would be seen later by the district nurse because they came every day. The deputy manager told us they thought the district nurse might have already seen this person's arm as they had a dressing on. We had to explain that the dressing was for a previous issue and not related to the bruising. We saw the district nurse later in the day and asked if they were attending to the person's arm. They told us they had not been informed about it but would take a look. The district nurse also told us they came every other day and not every day as we had been informed.

Staff we spoke with were able to give examples of how they would know if a person was in pain or unwell, such as not eating, not drinking, crying, becoming withdrawn. However, staff said that this was sometimes difficult to identify because they were so busy

These examples demonstrate that the provider had failed to make sure that the care and treatment of people living at the home was appropriate and met their needs. This is a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were not enough chairs available in the lounges for people to sit comfortably. Some people spent several hours sitting on dining chairs. One person told us they were very uncomfortable sitting in a dining chair. We also saw people arguing with each other when they perceived somebody had taken their chair. When we spoke with the manager about this they said they had identified this and had put in an order for new chairs. We suggested that, for people's comfort, it might help to bring armchairs from some of the empty bedrooms. This was done for the person who had told us they were uncomfortable and they thanked us for our intervention.

This meant the provider had failed to provide equipment accessible at all times to meet the needs of the people living at the home. This is a breach of regulation 15(1)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

During our visits we asked people who lived at the home and a visiting relative if they felt cared for and if they had their privacy and dignity needs were met. Two people said "They are always friendly" and "I have never seen the staff being unkind or speaking nastily to anyone." The visitor to whom we spoke said "I have never had any concerns about the care and dignity here." However when we spoke to another person who lived at the home, they gripped our hand very tightly and said "please don't go. I need some kind people". Two other people made allegations to us about staff handling them roughly and another person said "Nobody, nobody gives a care here."

Examples of staff demonstrating a caring approach were few. We observed one particular member of staff attempting to take a person centred approach and talking to people about their history, holding their hand and offering reassurance, listening to people and offering, albeit limited, choices. We also saw some staff spoke with people at face to face level and tried to support their needs. However, because there were so few staff available, this meant staff time was mainly task focussed and there was little time for staff to stop and take time to observe and listen attentively to what people needed. We saw staff ignored people as they were engaged in other tasks, even though people made it clear they needed support.

We saw staff ask one person if they were okay. When the person replied "No, I'm not", the member of staff continued to walk by and ignored the response. Another person asked staff if they could eat their lunch in the lounge, so that they could continue to watch a television programme. Other people were also staying in the lounge. However, this person was told by a member of staff "No, you know that you eat your dinner in the dining room."

We saw where people sat passively they were ignored and where people attempted to be heard or noticed they had to persist in order to gain staff attention. For example, one person called out five times before staff attended to them. Another person repeatedly held their hand out to try to communicate with staff before this was noticed.

We saw one person who was extremely distressed. They were clearly unhappy, wringing their hands and saying "oh no, oh no," and looking anxiously round. We saw staff walked past and asked the person 'are you alright?' but did not stop to wait for an answer or even notice this person's distress. We saw the person cried to themselves and muttered: "oh my god, what is this place".

We saw that staff when undertaking tasks on several occasions only physically interacted with people, for example at meal times when they provided people with side tables, cutlery and meals without any verbal interaction.

During our first day of inspection we conducted two SOFI (Short Observational Framework for Inspection) observations where we followed the care of seven people over the periods of one hour and forty minutes respectively. When we analysed the data from one of these observations during which we had tracked four of the people living at the home we saw the following results: for 22% of the time people engaged positively with people or objects such as television, radio, newspaper, this included enjoying speaking with other people or actively engaging in an activity, for 17% of the time there were negative engagements, this included people being upset or angry, the remaining 61% of the time were neutral interactions, this included people just sitting quietly not engaging with anything or anybody.

Staff did not always appear to be considerate of people's dignity needs or treat them with respect. Prior to our inspection we had received information that people's clothing was not cared for well and that people often wore each other's clothes. When we looked in people's drawers we found underwear belonging to other people. In one person's drawer we found underwear with four different people's names on it.

A visitor told us they had asked that their relative wear their slippers but this had not happened and the slippers were missing. We saw people in shoes and slippers which clearly did not fit them. When we asked staff if they belonged to the person, they removed them and brought other footwear.

Staff often spoke about people either in front of them or in front of others without considering the person's privacy and dignity. For example we saw one person in a state of distress saying "I'm a nutter, I've no life, I'm no use." The member of staff who was with this person called across the room to the manager saying "(Name) is having a lucid moment".

Inadequate

Is the service caring?

Another example was when we heard a member of staff calling to other staff across the length of the room, that a person who lived at the home had been found 'starkers' in their room again. We also saw agency staff who were not familiar with people point at them and ask other staff "What is their name?"

We observed one person ask the staff member who was administering medicines if they could have a cigarette. The staff member was wearing a tabard which gave the instruction they were not to be disturbed as they were administering medicines. The staff member pointed to their tabard and said "you can see I am doing something, you can read, you can see I am not to be disturbed". The person told us that they struggled to read.

We saw people with food left on their hands, faces and clothing after meals and people wearing dirty and stained clothing. On the third day of our inspection we saw one person wearing the same clothing they had been wearing on our second day of inspection two days previously. The clothing had clearly not been changed as it had the same food stains we had seen on our previous visit. We saw from records that this person had refused to go to bed for the two nights between our visits. When we asked staff if they had been supported to change their clothing during this time they said they didn't know.

We saw people with dirty nails, with dirty and unkempt hair and gentlemen in need of shaving. One lady told us they would like to have their hair done but had no money to pay for that. One gentleman told us he did not like not being shaved.

Our tour of the home showed other examples of how people did not have their privacy and dignity needs met. For example, some of the bedrooms had a toilet in the corner of the room. This area should have been curtained off for privacy. Many of the curtains were missing and the ones remaining were either too short or did not pull across the whole of the curtain track. We saw beds that were made with dirty linen and dirty odorous mattresses which further indicated a lack of regard for people's dignity.

This meant the provider had failed to make sure that people living at the home were treated with dignity and respect and ensure their right to privacy. This is a breach of regulation 10(1) and 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw two occasions when staff laughed at people. One was a person who, due to their confusion, had become very distressed believing their family were in danger. Although there were a few staff in the vicinity as this person walked up and down the corridor loudly voicing their worries, nobody sought to offer reassurance and a member of agency staff laughed at the person. We intervened to reassure this person. On another occasion a lady who lives with dementia had removed their jumper in the lounge. Again we intervened discreetly to protect the person's dignity but when a member of staff became aware of what had happened, they approached the person laughing loudly and pointing out what the person had done.

On two of the days of our inspection we saw one person walking around with their trousers permanently unfastened and falling down. Although we heard other people at the home express their concern at this, staff did not take any action to support this person to dress more appropriately and therefore protect their dignity. Staff did however speak loudly with each other about this person saying they were "flashing."

This meant the provider had failed to safeguard people who lived at the home from improper treatment. This is a breach of regulation 13(4)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We asked people who lived at the home about what was available to engage them during the day. People said "We don't faff about with things to join in with. There are various things to do. Read the paper", "We do puzzles and things like that." Other people said "It's awful, really awful. There's nowt to do but sit all day", "It's driving me mad being in here" and "I know I'm old but this is not nice to be doing nothing".

People were not given genuine choices in matters that affected them daily. Although staff sometimes asked people what they would like, staff made decisions without checking with people properly. For example, staff presented people with drinks without always asking what they wanted or brought meals to people in the lounge without checking if that was where they wanted to eat. Staff we spoke to about this said they usually knew who liked what. This meant staff were assuming, rather than consulting with people, preventing them from making their own choices.

We heard one person ask to be supported to go to bed we heard staff tell them: "You'll have to wait; we are doing people in order". We also saw that people had little choice about when they got up in a morning. We looked in the care plan for a person who was up and dressed but asleep in the chair when we arrived at the home at 7am. The care plan for this person said they liked to lie in.

We saw little record of people's choices and preferences within their care plans. Where we did, the record was minimal, not always accurate and we observed that staff did not respect the choices recorded. For example one person's care plan said they liked to be involved in different activities. When we spoke to this person they said they did not like to join in but kept themselves to themselves. We saw this persons choice of drink to be 'coffee no sugar', however we saw the person given tea with sugar on two occasions.

When we asked staff about person centred care, they did not show any understanding of this concept but did speak about reading people's care plans. One member of staff said that they took the time to read people's care plans to try and find out more about each person they care for. Other staff, however, said that they did not have time to do this as it was not structured into the day.

We saw that people who liked a cigarette had to line up outside the cupboard where cigarettes were stored at specific times. They were then escorted down the corridor by staff to the smoking room. On one occasion we saw six people sitting in the very small smoking room. Two of these people were in wheelchairs and had been positioned one behind the other in front of the people sitting on chairs. This meant there was no room for people to move. A member of staff was looking through the glass window of the door at the people inside. They said they had to do that as "it's not safe to leave them."

The deputy manager told us they did not have time to take people for a cigarette when they wanted one, so they all had to go together. This example is illustrative of institutionalised practice and demonstrates a lack of person centred care.

We saw that recording of people's needs and preferences in relation to their social and recreational needs was minimal. Some people's care files included brief social histories but others did not.

We saw that televisions were on in both lounges throughout all of our visits. The televisions were mounted on the walls in a high position, chairs were placed underneath them and people were either unable to see them clearly or, if they were sitting beneath them, not at all. When we asked people if they had chosen what they wanted to watch they said they hadn't. One person said "They just put it on, they don't ask us." On the second day of our inspection we saw that formula 1 racing was showing on the television. We asked people if they liked this. All of the people we asked said they did not. We asked staff if they could find a programme people might like to watch. A programme with people singing hymns was found and we observed several people start to join in, either singing or humming along to the hymns. This showed that if people were given a choice they were able to respond positively.

Although there was an activities coordinator in post we found there were no meaningful activities taking place at the home. We saw what was described as a sensory session, in which the curtains were drawn in one lounge and there was soft music and lights, people involved appeared dis-interested in this activity. When asked about this one person frowned and told us: "I don't know what was going on there".

Inadequate

Is the service responsive?

We saw the advertised weekly activity programme described the following activities; Monday: Out in the Garden, Tuesday: Blank, Wednesday: 1:1 time, Thursday: Hairdresser, dominoes and Friday: Sensory morning. Saturday and Sunday were absent from the timetable. The programme did not evidence activities that had been tailored to the needs of people living at the home, particularly those living with dementia or designed to provide therapeutic or life-enhancing stimulus.

On day three of our inspection the activities co-ordinator took a box of memory cards round to people in turn. She explained these were to encourage people to remember film stars. However, we saw some people did not want to do this and others quickly lost interest. This activity continued regardless of other people in the room needing attention.

One person who was sitting beside a music player told us: "Don't ask if I'm enjoying the music because I'm not. I'm sick of hearing it; I've heard it that many times before".

We found music was played intermittently and loudly in both lounges. The music was repetitive and in one lounge the CD player kept sticking with loud 'clicks' that made some people jump. Not all of the music was appropriate, for example, a Christmas song was played.

This meant the provider had failed to make sure that people who lived at the home received person centred care that met their needs. This is a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people what they would do if they wished to make a complaint. People said "I don't have much to complain about. I can't really say what I would do if I did" and "If I wanted to make a complaint I'd speak to someone. I'm not sure who." A visiting relative told us they had not had occasion to consider making a complaint, but would be confident in speaking to staff if they did.

We saw the complaints record had one complaint recorded since 2008. However we had been informed about two complaints made to the home much more recently. We did not see any documentation relating to these. Throughout our inspection we heard people complaining about various things, such as having to wait for a drink, for a cigarette, for meals and for the toilet, yet people's complaints were not acted upon.

This meant the provider had failed to make sure that any complaints were investigated and acted upon. This is a breach of regulation 16(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People we spoke with could not tell us about any proactive ways in which the home sought their feedback through meetings, surveys or questionnaires. However one visitor we spoke with said they had recently completed a satisfaction questionnaire.

The manager told us she had only been in post for two weeks. She said she had a lot of work to do to raise standards in the home. She told us she had worked long hours because there was much to do, but said there was not always management presence in the home during the weekends. She told us she was available on call 24 hours a day to support staff.

The manager told us staff lacked the skills to care for people properly and this was an area she planned to address, along with improving the staffing ratios and care records. However, in spite of the manager identifying poor standards of care, we found there was little action being taken by them to address the more immediate areas of risk. For example, the manager had told us bed rails were hazardous, yet had not taken any action to ensure the safety of the people using them. The manager had made no attempt to increase the numbers of staff on duty until we requested this, despite her identifying people were at risk of unsafe care due to poor staffing levels.

The manager was not visible in the service and the office door remained closed when she was working in it. Staff lacked direction and we saw on several occasions they asked one another what they were meant to be doing. On day three we saw staff were not deployed effectively and seemed oblivious to people's needs. For example, we saw staff pushing the vacuum cleaner whilst one person was asking repeatedly for help to go to the toilet. We asked staff if they could help people and they said they had been told to do the cleaning up.

Staff told us they were unclear of their roles and responsibilities. Most advised that they "get stuck in" and help in all areas wherever there is need. One member of staff said they felt they lacked direction. We overheard staff expressed dissatisfaction in the hours they worked and when they could take a break. We heard one member of staff say to a person: "I'm so tired I can't wait to finish today and go home".

The manager told us audits were carried out by the deputy but she did not think these were robust enough to ensure there was quality of care for people. On the second day of our inspection we saw some documents used to check the quality of the service. These were mainly checklists and were not all up to date. We saw records which stated they were audits of medication, yet these were tick lists and some of these were blank. Some of the quality assurance documentation the manager thought was in place could not be found by the manager and although she told us she audited the quality of the service daily, this was not documented as she had been 'crisis managing' since her arrival in post.

The manager told us she was not aware of people's names in the home as she had been unable to do anything other than 'crisis management'. The manager told us this home had 'awful care practices' which were institutional.

The manager told us that care records were inaccurate and out of date and we found evidence of some records having been falsified. We found that the system for maintaining records was chaotic and the manager struggled to find many of the items we requested.

We found that the provider had little involvement in the governance of the home. This meant they had no oversight of any issues of concern within the home.

This meant the provider had failed to establish or effectively operate systems and processes to assess and monitor the quality and safety of the service. The provider had further failed to make sure accurate records relating to the care of the people living at the home and the management of the service. This is a breach of regulation 17(1) and 17(2)(a)(b)(c) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we became aware of a number of incidents which had occurred in the home which the Care Quality Commission had not been notified about. These included accidents and incidents at the home. In addition the manager had failed to report their concerns about the safety of the people living at the home to the relevant authorities.

This failure to report demonstrates that the provider had failed in their duty of candour. This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider had failed to make sure that people who lived at the home received person centred care that met their needs.**

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had failed to make sure that people living at the home were treated with dignity and respect and ensure their right to privacy.**

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had failed to ensure the safe care and treatment of people living at the home.**

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had failed to maintain the safety of people living at the home.**

This section is primarily information for the provider

Enforcement actions

The provider had failed to make sure that people who lived at the home were not deprived of their liberty without lawful authority.

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider had failed to make sure that the nutritional and hydration needs of the people living at the home were met.

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had failed to provide equipment accessible at all times to meet the needs of the people living at the home.

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The provider had failed to make sure that any complaints were investigated and acted upon. This is a breach of regulation 16(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to establish or effectively operate systems and processes to assess and monitor the quality and safety of the service. The provider had further failed to make sure accurate records relating to the care of the people living at the home and the management of the service.

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to make sure there were adequate numbers of appropriately trained staff on duty to maintain the safety of people living at the home.

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Concerns about the safety of the people living at the home were not reported to the relevant authorities. This failure to report demonstrates that the provider had failed in their duty of candour.

The enforcement action we took:
Notice of decision to vary condition of registration to remove a location