Abbey Park House

Abbey Park House

Inspection report

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Abbey Park House is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection, some who were living with dementia. It does not provide nursing care. The service can support up to 28 people.

People's experience of using this service and what we found
Risks to people's health, wellbeing, safety and the environment were inadequately managed, and people were placed at risk. Some people had not received their medicines as prescribed. Staffing levels were not always sufficient to meet people's assessed needs and level of support. There were continued concerns with staff practices and the environment regarding infection prevention and control.

The provider did not ensure staff had the skills, training, knowledge or experience to meet the individual needs of 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 provider's policies and systems did not support good practice. The environment did not meet people's needs and well-being. People shared mixed views about food. People told us they had access to health professionals when needed.

People did not receive a service that was caring and individual to them. People were not treated in a consistently respectful and dignified manner and the care and support they received did not consider their past lives, feelings and aspirations.

People did not receive personalised care which met their needs. Staff did not know what people's needs were and how support should be provided. People did not have the opportunity to undertake interesting and stimulating recreational activities they enjoyed. People, however, told us they felt confident to raise a complaint.
Leadership within the home was inadequate and had failed to ensure positive outcomes for people who lived there. The registered provider's systems failed to ensure people received the care and support they needed and had failed to monitor the quality of the service and ensure people were protected from harm. The provider had not taken sufficient action to address many of the concerns we highlighted in our previous report.

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 Inadequate (published 05 December 2018) and there were multiple breaches of regulation. The service was placed in Special Measures. We placed conditions on the provider's registration which required them to send us monthly reports. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

This service has been in Special Measures since October 2018. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains as Inadequate overall. Therefore, this service remains in Special Measures.

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abbey Park House on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches in relation to safe care and treatment, dignity and respect, person-centred care, staffing and good governance at this inspection.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. Services in special measures are kept under review. Following the inspection, we took urgent action to ensure people were not exposed to ongoing risk of harm. At the time of the publication of this report, our action had been completed and there were no longer any people living at the service which is now closed. Therefore we will had not taken any further enforcement action.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Abbey Park House

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 and one assistant inspector on the 04 June 2019 and one inspector on 05 June 2019.

Service and service type
Abbey Park House 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 was not registered with the Care Quality Commission although the provider was registered. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There has not been a registered manager in post since November 2018.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with six people who used the service about their experiences of the care provided. We spoke with seven members of staff including the nominated individual, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 Inadequate with breaches of Regulation 12, safe care and treatment, Regulation 13: Safeguarding service users from abuse and improper treatment and regulation 18: staffing. At this inspection this key question has remained the same. The provider had not complied with their action plan or made the necessary improvements to ensure people received safe care and treatment. There was a continued breach of Regulation 12 Safe care and treatment and Regulation 18: Staffing. The provider had met Regulation 13: Safeguarding service users from abuse and improper treatment.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● We identified serious concerns around the registered provider's ability to effectively assess and manage the risks to people living at Abbey Park House. Whilst some risk management plans contained information and guidance for staff about how to support people safely, we observed staff practice placed people at risk of harm.

● For example, three people had been assessed as high risk of choking. One person's care plan noted they must use a tea spoon when eating their meals and staff must always assist them when eating and drinking. However, on day one and day two of our inspection we observed the person eating a meal with a knife, fork and desert spoon and without the assistance of staff. We had to intervene and ask for staff to support the person. This exposed the person to extreme risk of choking.

● We saw advice from the Speech and Language Therapist team identifying another person required a soft diet and thickener in their fluids. There was further health professional advice that the person should receive a high calorie, high protein diet with food supplements. We observed the person eating foods that increased their risk of choking. We intervened and advised the staff that the person was on a soft diet. Some of the care staff and the chef we spoke with were not aware of this person's dietary needs. This poor management and monitoring of people's eating and drinking put people at risk of harm.

● We saw advice from health professionals that the same person should have their food and fluid monitored to mitigate the high risk of malnutrition. The health professionals had set daily targets for both food and fluids. Staff told us that they were not aware that the person's food and fluids should be monitored. Records to document the food the person had consumed as well as confirmation by staff, showed that they had not been supported in accordance with this guidance. In addition, the fluid intake was not monitored effectively. It had not been recognised that they were not consuming sufficient fluids to lessen the risks caused by their health condition and the potential risk of dehydration.

● People were not protected from the risks of poor moving and handling practices. We observed one occasion when three staff supported a person to transfer with the use of a hoist and they were not confident in how to use the hoist safely. Whilst the registered provider advised us that staff had received training they had not put their learning into practice.

● Improvements were needed to ensure people's safety in the event of a fire. The registered provider had

not acted in accordance with the associated Health Safety Executive guidance for fire safety risk assessments in residential care premises. The registered provider had not considered the safety risk associated with highly flammable paraffin based preparations (topical creams) and the use of oxygen cylinders. A risk management plan was not in place and staff were unaware of the fire risk associated with the unsafe use of emollient creams and oxygen cylinders.
● At our previous inspection we found the maintenance room was left unsecured and unlocked. At this inspection we found the room continued to be unsecured and unlocked. Within this room we found products that could cause harm and pose a serious risk to people if they are ingested inappropriately.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care which placed people at risk of harm. This constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Preventing and controlling infection; Using medicines safely
● People did not live in a clean home and were not protected from the prevention and control of infection. There continued to be unacceptable levels of cleanliness which placed people at risk of cross infection. We found one communal bathroom, which was frequently used was soiled, stained and offensive smelling. There was no hand soap or hand sanitizer for people to use. We noted three bins in the bathroom that were full of used incontinent pads. We spoke with the registered provider and they agreed the communal bathroom was soiled and offensive smelling.
● We were concerned about the procedures in place to manage laundry safely. We found there were no red dissolvable bags. These are used to separate soiled laundry from non-soiled laundry and to prevent the risk of cross contamination. Although there had been no outbreaks of infection the standards in place would not safeguard people against the risk of infection.
● People were not protected by effective management of medicines in the service.
● For example, one person had anticipatory [end of life] medicines that contained controlled drugs. These were not stored in a locked controlled drugs cabinet. Controlled drugs are medicines which required certain management and additional control measures.
● One person had not had access to medicines to manage their health condition in accordance with prescribing guidance. This pain relief was prescribed to be administered on a daily basis. However, staff told us the medicine was only being administered as a PRN medicine (as and when needed). Records we reviewed showed that the person had only received this medicine once from the day it had been prescribed in April 2019. In addition, senior care staff had administered this medicine and were not trained to do so. This practice put the person at risk of experiencing unnecessary pain and discomfort because they had not received the medicine daily and staff had not received training in order to do this safely.

We were not assured that all reasonable steps had been taken to reduce risks associated with the detecting and controlling the spread of infection and the safe management of medicines which placed people at risk of harm. This constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Staffing and recruitment
● One person told us that on occasions staff did not respond to them in a timely manner and told us, "It all depends if staff are busy." From our observations sufficient staff were not always deployed to meet people's needs. When we arrived on day one of our inspection we found the number of staff on duty ran below the staffing levels the provider had assessed as being required. We saw people were left for periods of time with no interaction from staff as they were undertaking other duties.
●During day one of our inspection there were no dedicated staff available to carry out domestic duties

which contributed to the poor cleanliness of the environment. No risk assessments or related actions had been taken to consider the impact of this on the staff team and their roles and responsibilities.

The registered provider had failed to ensure there were sufficient numbers of staff deployed to meet people's care and treatment needs. This constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

● We looked at the way in which staff were recruited and found that the provider carried out pre-employment checks prior to offering them a job. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Following the concerns found at this inspection, CQC made four safeguarding referrals to the local authority for them to consider under safeguarding procedures.
●The provider had met the breach of Regulation 13, safeguarding from abuse, that had been found at the last inspection. They had reported other incidents of alleged abuse to the local safeguarding team when it was identified.
• Staff were aware of how to protect people from the risk of abuse and knew how to raise concerns if abuse occurred. A member of staff told us, "I would contact CQC straight away."
● Although safeguarding concerns had been reported, on the days of our inspection we were unable to see how the provider investigated safeguarding matters, accidents, incidents and complaints and how they prevented reoccurrence. The home manager was not available on the days of the inspection and staff could not access the information which was stored electronically.

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 now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

●People told us that in their opinion staff had the skills and right experience to meet their needs. One person told us, "I get the impression staff know what they are doing when caring for others." Whilst some staff training had taken place since our last inspection, we saw that some staff did not put this into practice or did not have the skills or knowledge required to support people safely and promote their wellbeing.

● For example, whilst staff had received moving and handling training we saw two examples of poor moving and handling techniques demonstrating that staff did not consistently have the skills required to safely support people and as a result placed people at risk of injury.

● Whilst the staff we spoke with told us they received dementia training, we found they did not always have the skills or time to work effectively with people living with dementia. There was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. This meant that people were at risk of being supported by staff who may find it difficult to understand people's specific care needs.

● Staff told us they were observed by the manager and participated in supervision meetings. A member of staff told us, "I have 1-1 meetings with [name of manager]". However, records for staff competencies and supervision meetings were not provided during the course of the inspection, therefore, we were not able to establish that all staff had received regular competency observations in line with the provider's policy.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Support from health professionals was not always sought in a timely way. We found action had not been taken to follow up a referral made for a person in February 2019 to Speech and Language Therapists. This was actioned during our second visit at our request.

• Despite our findings people felt they received effective care and treatment from health professionals including opticians and chiropodists. One person said, "Staff call the doctor if I'm feeling unwell."

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

●People were not always supported to eat their meal. We observed staff placed meals in front of people without explaining what their meal was. People were not always shown the meal options on offer in a way that would help them to make a choice each day. This was not supportive of people living with dementia.

●At the last inspection we found that there were no pictorial menus in the dining room to help support people to choose their meals, at this inspection it remained the same.

● People shared mixed views about food. Most people told us the food was, "Alright." However, we found mealtimes were not a positive and pleasant experience for people. There was little attention to the dining environment. Staff were task focused and missed opportunities to interact with people.
● People told us they were not involved in the planning of meals and records we sampled confirmed this.

Adapting service, design, decoration to meet people's needs
● At our previous inspection we found that the home environment was not 'dementia friendly' with a lack of pictures and objects to occupy and stimulate. At this inspection we found little improvement. The service had not adapted the premises to improve people's quality of life and promote their well-being.
● There was little for people to find to enable them to engage in independent activity and a lack of signage to help people orientate to time and place. For example, the date on the notice board was 29 April 2019. There were some pictorial signs on doors to denote bathrooms and toilets.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
● One person told us, "Staff ask me if they can help me get dressed."
● Staff told us they had completed MCA training and were able to explain how to support a person who did not have the capacity to make a decision about their care and support.
● However, staff did not consistently gain consent from people. For example, staff were observed placing protective clothing on people without asking their consent or explaining what they were doing.

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 authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● The manager worked with the local authority to ensure the appropriate assessments were undertaken. Where applications under DoLS had been authorised, we found that the provider was complying with the conditions applied on the authorisations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Assessments of people's needs were carried out prior to them joining the home. Initial assessments we reviewed included people's medical, physical and social needs; personal care, medicines, eating and drinking and continence care.

Inadequate

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 with a breach of Regulation 10: Dignity and respect. At this inspection this key question has now deteriorated to Inadequate and the breach of Regulation 10: Dignity and respect remains.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- People did not experience kind and compassionate care. One person told us, "Staff don't care, but [name of manager] is okay." Overall the service provided at Abbey Park House was not caring and this could be demonstrated by the concerns found in the other areas of this report.
- The provider had not ensured care and support was delivered safely and that people's individual needs were met. The provider had not ensured people were cared for in a clean and comfortable environment. As a result, people experienced poor outcomes.
- Our observations showed that staff varied in their approach to those that used the service. Whilst we saw some kind interactions, we also saw examples where staff were dismissive and uncaring. When one person was being supported to eat their meal in a communal area, they requested to go to the bathroom. We saw a staff member telling the person to wait until after they had eaten their pudding and said, "You have a pad on." This compromised the person's human rights and dignity. We brought this to the provider's attention on the day of the inspection.

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

- One person told us that staff choose what time they get up and go to bed and said, "I don't have a care plan."
- People we spoke with could not recall being involved in their care plan or any meetings. Records we reviewed confirmed this.
- We saw very few occasions where there were positive interactions between staff and the people they were supporting. However, this was not consistent. Our observations throughout the day showed that interaction between staff and people seemed mainly task orientated, and when people required direct support with personal care, to move or when eating and drinking. We continued to observe people being supported with their personal care needs at set times during the day and we saw people being offered drinks and snacks at set times also.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not consistently respected and promoted. One person told us staff sometimes treated him in a manner which was 'childish' and said, "[My] legs are a problem, but my brain is okay." Although staff we spoke with were aware of how to promote people's dignity, this had not been

consistently practiced.

●We saw another person's dignity was not maintained. We saw a staff member administering a medicine patch behind their ear whilst they were sitting and eating their meal. Other people were also sitting and eating at the dining table.

●We saw the staff handover being undertaken within the manager's office. Confidential and personal information pertaining to people was discussed and could be overheard by anyone who lived at the home and, or who visited.

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

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 now deteriorated to Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

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

● People were not consistently encouraged to access and integrate with the local community with support from staff to reduce social isolation and maintain skills and independence where appropriate.

● People were seen to spend large amounts of time unoccupied, with televisions playing without people actively watching them or engaged in any other types of pastime. One person told us about their love of animals and how much they missed their pets. This interest was not recorded in the person's care plan and the person had not been supported to pursue this interest.

● Staff had little time to engage people in meaningful recreational activities of interest. We asked a member of staff what their plans were for the day and they told us, "We will be taking people to the toilet and then it's lunch time."

● On the days of our inspection we saw some recreational activities were supplied during the afternoon. For example, colouring and reading magazines but few people engaged in these and they had little meaning for people and their lives. One person told us, "I'm so bored. Feel condescended by staff, they have given me a child's colouring book."

●There were no plans in place to support people who lived in their rooms to pursue activities they enjoyed or help to prevent social isolation. One person told us, "I don't get to go outside as much as I would like to."

● Whilst there had been some work to develop people's care plans in relation to obtaining information about people's previous lives and interests, not all staff used this information in practice to ensure individual care and support was provided to people.

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

● People did not receive personalised care and support. From our observations, we saw that people's basic needs were often not met and that they did not receive care that was personalised to them. One person said, "Staff just do what they need to do for me."

● People's care plans were reviewed monthly, but these reviews were not meaningful. There was no evidence that people had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis. This meant there was little evidence that people had any choice or control over their own support.

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.

●The provider did not understand people's information and communication needs. There had been no attempt to design care plans in a way that meant people who lived at the home would be able to understand and comment on their contents.

● Information had not been adapted to support people who were living with dementia to make choices or to be kept informed of changes within the home. Menus, providing information about the meals that were available, were written on a white board and were not supported with other types of communication that might aid people's understanding and choice, such as photographs and pictures.

End of life care and support

●There was one person on end of life care at the time of our inspection. For this person we saw little person-centred detail in their care plans, however we were told these were currently being updated.

●There was some information recorded in other people's care plans about people's wishes and expectations for being supported at the end of their life. However, more work was needed to ensure end of life plans were person-centred to ensure people were supported to be comfortable, pain free and dignified at the end of their life.

The lack of robust processes to ensure care was personalised and able to meet people's needs effectively demonstrated a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People told us they knew how to make a complaint. One person said, "If I wasn't happy about something, I would talk to staff."

● Whilst a copy of the complaint's procedure was clearly displayed in the home it was not in a format that met everyone's communication needs.

● On the days of our inspection, we were unable to see how the provider investigated complaints and how they prevented reoccurrence.

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 and with a continued breach of Regulation 17: Good governance.

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.

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

- The service had not had a registered manager in the service since November 2018. As part of their registration, the provider is required to have a registered manager in the home. There was a home manager in place who had submitted an application to become the registered manager. The manager was not available on either of the inspection visits.
- Whilst improvements had been made to quality audits following our previous inspection, the provider had not acted on the findings of the audits. This meant the systems were ineffective and had placed people at risk of harm.
- Governance systems to monitor the safety of the service were inadequate. For example, whilst some risk management plans contained important information to support staff to provide safe care, this was not followed in practice. It had not been recognised that people who had been assessed as being at high-risk of choking were being given high risk foods. Neither had it always been identified that people were not being supported in accordance with external health care guidance.
- People's health and well-being was not sufficiently protected. The systems in place had not ensured people received the care and support they needed. For example, we found people's fluid intake was not being recorded consistently or monitored. People's nutritional needs had not been addressed or monitored. People's medicines were not always managed safely. We found failings in the provider's quality assurance systems around medicines management.
- The manager had completed health and safety audits of the home and had identified potential hazards. For example, exposed pipes, sockets hanging off the wall and unsafe mattresses and poor fire safety. These safety issues had not been addressed or resolved by the provider.
- There were systems in place to ensure the service was adequately staffed. However, on the first day of our inspection we observed inadequate deployment of staff to enable person-centred care and a good quality of life.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered provider was present during both of our visits and we shared our inspection findings with them. They were unable to explain why their governance systems had failed to identify the significant short

falls we had found. Following our visits, we requested and received information which assured us action was being taken to mitigate the extreme risks we had identified for people.

● The registered provider had failed to ensure people received person-centred, dignified and respectful high-quality care and good outcomes for people. There was a culture of task-centred instead of person-centred care. There were no effective systems in place to ensure that people were given choice and control over how they preferred to spend their days.

● People told us, and records corroborated that they were not involved with the planning and reviewing of care plans.

● There were no systems in place to ensure people were given information in a way they could understand to enable them to communicate effectively.

●The manager had notified Care Quality Commission (CQC) of events which had occurred in line with their legal responsibilities and in line with the duty of candour. They had displayed the previous CQC inspection rating as required.

● Any notifications the manager and provider were obliged to make such as those alleging abuse, had been made to the CQC and local authority.

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

● People told us they knew who the manager was and felt they were approachable. One person told us, "I know who the manager is, he listens to me."

● Whilst there were systems in place to involve people in service improvement, people's views about the quality of care they received had not been sought effectively. People we spoke with told us they were not formally asked about their views and experiences about the home. One person told us, "Nobody takes any notice and nothing would be done." People had not been empowered to make suggestions that would improve their quality of life and had not been given the opportunity to shape and improve the service.

●The provider's values of wellness, compassion and kindness were not always implemented in practice. Staff were not consistently observed sharing friendly interactions with people, respecting their choices, equality and diversity as well as their right to make decisions.

● Staff told us they had opportunities to attend meetings with the manager to discuss the service and raise any issues. A staff member said, "[Name of manager] has made some real improvements." Staff told us they felt supported in their role and found the manager helpful and approachable.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

● Adequate provider oversight to drive improvement was ineffective. Despite carrying out regular audits, including those completed by the manager, the standard of care people received was poor.

●There were systems in place to check the competency of care staff to ensure they were equipped with the skills needed. However, these were ineffective as we observed staff not applying their learning into practice.

●The quality assurance systems were limited in their effectiveness to ensure continuous improvement. We identified widespread failings in several areas which should have been addressed through the operation of robust systems of governance, audit and monitoring. For example, we found several areas of the building were not kept in a clean, well-maintained and hygienic state.

● The manager worked in partnership with other professionals and agencies to help meet people's needs. This included working with GPs, community health services and the local authority.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences. Regulation 9 (1) (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm due to inadequate risk management processes within the service. Regulation 12 (2) (a) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in

place to monitor the quality of the service.

The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.

Regulation 17 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there were sufficient numbers of staff deployed to meet people's care and treatment needs. Regulation 18(1)