

Little Oyster Limited

# Little Oyster Residential Home

## Inspection report

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## Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

# Summary of findings

## Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

### About the service

Little Oyster Residential Home is a residential care home providing personal care to 54 people at the time of the inspection. The service can support up to 64 people. The main building is divided into two floors and an annex, and there are separate bungalows and apartments where people live more independently. The service accommodates people who have learning disabilities, mental health conditions and physical disabilities.

### People's experience of using this service and what we found

#### Right Support

Staff did not provide effective support to identify people's aspirations and goals and assist people to plan how these would be met. Staff did not always focus on people's strengths and promote what they could do. There was not a consistent approach to supporting people to learn new skills or maintain their skills for as long as possible, where this was appropriate. Records showed basic preadmission assessments had been carried out to identify people's needs. These assessments had not always been used to develop people's care plans.

The service had systems and processes in place to safely administer and record medicines use, however these were not always followed. Medicines were not managed safely. Medicines were not always administered in line with the prescription. Some people had not received their medicines as prescribed.

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 service provided people with care and support in a clean and well-equipped environment. The service was undergoing a programme of redecoration and repair.

#### Right Care

People's care was not always person centred and did not always meet their assessed needs. Care plans and risk assessments contained conflicting information. People's preferences had not always been recorded which meant people did not always receive care as they would like.

Although most people received improved experiences in relation to their dignity, respect and human rights,

the provider had not treated people with dignity and respect.

Staff had training on how to recognise and report abuse and they knew how to apply it. Although staff we spoke with understood how to protect people from poor care and abuse, abuse had not always been identified and reported to make sure people were safe from harm. Registered persons had failed to follow safeguarding policies and procedures. The service had enough staff to meet people's needs and keep them safe. Most staff had the necessary training to meet people's assessed needs.

#### Right Culture

Since the last inspection, people, their relatives and staff had been encouraged and supported to provide feedback about the service. Most people and staff felt listened to. Some staff did not always feel the same. Complaints made to the service had mostly been responded to in line with the providers policy.

The provider's quality monitoring processes were not robust and had not always identified concerns and improvements in the service identified during the inspection. There was no senior manager or provider oversight of the quality monitoring processes. This meant that the quality of service provided had declined since the last inspection.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection and update.

The last rating for this service was requires improvement (published 3 August 2022). There were 6 breaches of regulations. We served the provider conditions on their registration and a requirement action. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations. This service has not been rated good for the last three consecutive inspections.

#### Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

#### Enforcement

We have identified breaches in relation to risk management, medicines management, safeguarding people from abuse, assessing and designing care needs to ensure people receive person centred care, mental capacity and good governance. Please see the action we have told the provider to take at the end of this report.

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

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when

we next inspect.

#### Special Measures:

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

### Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

### Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

### Is the service responsive?

Requires Improvement ●

The service was not always 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.

# Little Oyster Residential Home

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

The inspection was carried out by 2 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.

#### Service and service type

Little Oyster Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Little Oyster Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

#### 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, which included monthly reports that the provider had sent CQC as part of their conditions on their registration. We gained feedback from the local authorities and other professionals who work with the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

#### During the inspection

We spoke with 13 people who used the service about their experience of the care provided and 6 relatives. We spoke with 17 members of staff including the registered manager, digital transformation manager, head of care, quality and compliance manager, neighbourhood leads, senior support workers, support workers, kitchen staff and members of the maintenance team.

We observed staff interactions with people and observed care and support in communal areas. We reviewed a range of records. This included 31 people's care records and medicines records. We looked at 3 staff files in relation to recruitment, staff supervision and training. A variety of records relating to the management of the service, including checks and audits, fire safety and maintenance records were reviewed.

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse. When there had been an incident of physical abuse between 2 people living at the service (which was a safeguarding concern), this had not always been appropriately identified, reported and dealt with. The local authority and CQC had not been informed.
- The provider had safeguarding policies and procedures in place. However, registered persons had failed to follow the policies and procedures.
- Staff told us they felt comfortable to report concerns to the registered manager. They felt that concerns were taken seriously, and appropriate action would be taken. Most staff had received safeguarding training and knew how to escalate concerns to outside organisations such as the local authority safeguarding team and CQC if necessary. However, staff had not always identified neglect and acts of omissions (such as missed medicines) as abuse and reported safeguarding incidents of neglect to the management team.

Registered persons had failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Despite our findings, people told us they felt safe. Comments included, "I feel safe here. Everyone is looking out for me"; "I feel reasonably safe"; "I feel safe with all the carers, they chat to me and ask questions"; "I feel safe since I got a brand new pull cord"; "I feel safe. There is always people around and they seem to know what they are doing" and "I feel safe, there is always someone around. I have a call button."
- Relatives also told us their loved ones were safe. One relative said, "I do feel she is safe." Another relative told us, "I feel he is safer there than where he was before. His physical wellbeing is well looked after."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At the last inspection in February 2022, risk assessments were inconsistent. They did not provide clear guidance to staff about how to meet people's needs safely. Risks of harm had not always been considered. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- At this inspection, risk assessments still contained unclear guidance for staff on how to meet people's needs safely. Some risk assessments conflicted with other information in the care plan and care records.
- Risks around constipation had not been well managed. Bowel charts had not been routinely monitored to



check that people had opened their bowels frequently enough to stay healthy. One person became uncomfortable and distressed during the inspection because they were constipated. They had not opened their bowels for 6 days. They were not given laxative medicines when they asked for them which led them to self harm later in the day.

- Risks relating to people's health needs were not always identified and addressed in a timely manner. For example, a person's care records showed that they had deteriorated in health from 29 December 2022, their food and fluid charts showed a reduced intake of food and fluids since that date. Staff had not taken action until 4 January 2023.
- Risks relating to people's weights had not been appropriately managed. One person had not been weighed by staff. Staff told us this was because they refused to be weighed and were weighing themselves. There was no oversight of the person's weight. The person was visibly thin. Staff told us the person did not eat any meals and chose to purchase meal replacement supplements over the counter instead. Their risk assessment stated they were 'malnourished and underweight'.
- Risk assessments did not provide clear guidance to staff about how to meet people's needs safely; epilepsy risk assessments did not include additional risks to service users and how these can be mitigated. One person's epilepsy care plan identified triggers; constipation, stress and excessive heat. The risk assessment in place did not evidence how staff should mitigate the risks identified in the care plan when supporting the person. The risk assessment had not considered equipment such as epilepsy sensors to support staff in identifying if the person was having seizure activity whilst spending time alone in bed. Another person had no epilepsy risk assessments in place at all.
- Risks relating to choking had not been well managed. One person had been assessed as at risk of choking and prescribed one scoop of thickener per 200mls of fluid. Their fluid charts showed that thickener had not always been given as prescribed.
- Diabetes risk assessments were not always clear for staff to know and understand what actions they should take to support people to manage their diabetes. There was no information about what staff should do if people's blood sugar levels were very high or very low. One person's diabetes risk assessments did not provide guidance to staff about signs and symptoms of hypoglycaemia or hyperglycaemia.
- The provider had an inadequate system in place in relation to accidents and incidents; which placed people at risk. Accident and incident records evidenced that timely and appropriate action had not always been taken to address incidents. One person had fallen and required hospital treatment. This had not been reported to the person's local authority care manager or their relatives. Another person had choked whilst eating twice in 7 days and no referral had been made to the Speech and Language (SALT) team.
- Incidents involving people showing anxiety and distress had not always been recorded.
- At our last inspection in February 2022 we reviewed an accident form which showed that a person had tripped over a hoist in the corridor and injured themselves. The management review of the accident detailed that hoists should not be stored in corridors. At this inspection, we found that the practice of storing hoists in corridors had reverted back and the arrangements to mitigate risks were not in place to keep people safe. On each of the 4 days of the inspection, the hoists were observed stored in corridors around the service. The hoist risk assessment showed that hoist mast should be stored at the lowest setting to avoid people becoming injured. We observed none of the hoists had been stored in this way. The risk assessment had not identified that a person had been injured from tripping over the legs of the hoist.

The provider has failed to protect people from risks related to health needs including choking, diabetes, constipation and epilepsy had not been assessed and care had not been planned to keep people safe. Accidents and incidents had not always been responded to and reviewed. This placed people at risk. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Using medicines safely

At the last inspection in February 2022, the provider had failed to manage medicines safely which put people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- At this inspection, people had not received their medicines as prescribed. Medicines were administered at set times of the day. People who were asleep when medicines rounds took place were not offered their medicines when they were awake. Records showed that sometimes those administering medicines were not following the prescriber's instructions. Some medicines were given at the same time as other medicines, which conflicted with the manufacturer's guidance. We could not be assured that people were always receiving their medicines in line with the prescriber's intentions.
- People prescribed 'as and when required' (PRN) medicines did not always have the appropriate protocols in place to support staff to know how or when to administer these medicines. We were not assured these medicines would be given appropriately or staff would know when to escalate concerns. Some people's PRN medicines were missing from the medicines administration records (MAR).
- People living with diabetes had not always received their insulin and other medicines as prescribed and blood sugar levels had not been consistently recorded.
- Temperature monitoring was not always taking place for medicines rooms and people's own rooms where medicines were stored. There was no minimum or maximum temperatures being recorded. One medicines fridge had not been checked appropriately and was found to be full of ice, which meant medicines could have been stored at a lower temperature than required. This had not been identified by staff.
- Medicines, including drugs that are subject to high levels of regulation, were not always recorded in line with legal requirements. We reported our medicines concerns to NHS Kent and Medway Lead pharmacists, who carried out visits to the service following our inspection.

The provider had failed to ensure medicines were managed safely. This was a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Staffing and recruitment

- At the last inspection in February 2022, we observed one occasion where a call bell had been muted or switched off without staff attending to the person to find out what they wanted or needed. This was an area for improvement. At this inspection, some people told us their call bells were answered quickly and this had improved. However, some people told us there were still some delays. The management team had developed an audit to check people's experience of call bell responses and were continuously taking action to address shortfalls.
- People told us, "There aren't always enough staff. Sometimes I have to wait for them to come. I know why they aren't coming, because there aren't enough of them. If I want something, I call out"; "Sometimes I have to wait, like this morning, about 10 minutes"; "I press my buzzer if I need something. They come in a reasonable time"; "I like having carers here 24/7. When they are short staffed it is hard and I have to wait for help"; "They have really stepped up on the call bell answering before it was touch and go, now they are bang on it especially at night" and "I have a panic button and people come running if I press it."
- The provider had recruited staff safely. Disclosure and Barring Service (DBS) criminal record checks were

completed as well as reference checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

- Rotas showed enough staff had been deployed on shift to meet people's assessed needs. The provider had a dependency tool in place to determine safe staffing levels. There appeared to be enough staff to meet people's needs. Staff told us there were usually enough staff on shift but if staff called in sick, additional staff could be slow to be deployed. The management team told us if there were staff shortages members of the management team were deployed on shift to provide support.

#### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service. People were COVID-19 tested before admission and isolated on admission where necessary.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The local Environmental health team also inspected the kitchen at the service on 12 January 2023 and awarded a 5 star rating.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

#### Visiting in care homes

There were no restrictions on people receiving visitors at the service. We observed people receiving visits from their relatives during the inspection.

# 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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At the last inspection in February 2022, people's assessments had not been reviewed and updated when their needs changed. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- At this inspection, there had been new people who had moved to the service since the last inspection. Records showed basic pre admission assessments had been carried out to identify people's needs. These assessments had not always been used to develop the person's care plans.
- One person had lived at the service for 2 months and had no care plan in place and no moving and handling assessments in place. Another person had lived at the service since the middle of December 2022, their referral information from the hospital indicated they should be on a soft mashed diet and needed prompting with meals. A care plan was not in place in relation to this and food records did not always evidence that this had been provided. This meant staff did not have all the information they needed to provide safe and effective care.
- Assessments included information about the care and support people needed with their nail care. However, staff were not always following the assessment and care was not always provided following this. We observed people with long fingernails, some people had hands that were contracted due to their physical health needs. This had also been identified at the previous inspection.
- The assessments and re assessments of people's needs had not led to goals and action plans being set to support people with learning disabilities to develop and improve their skills and maintain certain levels of independence, this meant there were no clear pathways to future goals and aspirations, including skills teaching in people's support plans.

The failure to provide care and treatment to meet people's assessed needs is a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

- People's experiences in relation to access to healthcare were inconsistent across the service. Records

showed some people had been supported with medical appointments, dentist appointments and chiropody. However, we found changes in people's health had not always been identified in a timely manner.

- People who were constipated did not always get adequate support to relieve their symptoms in a timely manner. There was no oversight of bowel monitoring to ensure people were free from constipation. One person had deteriorated in health from 29 December 2022 and had been declining meals and drinks, staff only identified that the person required some medical support on 4 January 2023.
- People had not always been registered with the GP who provided the Little Oyster with weekly visits in a timely manner. One person had moved to the service on 19 December 2022 and had not been registered with the GP. The GP service did not receive a request to register the person until 4 January 2023.
- A healthcare professional told us that people's changing health needs had not always been appropriately identified in a timely manner.
- Records evidenced people had not always drunk enough to stay healthy and well. There was no oversight of fluids drunk within a 24 hour period.
- People's weight had not always been monitored and recorded to ensure they were receiving appropriate nutrition. Some people had not received their meal supplements as prescribed as they were out of stock.

The failure to provide care and treatment to meet people's assessed needs is a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Ensuring consent to care and treatment in line with law and guidance

At the last inspection in February 2022, people's care plans contained conflicting and confusing information about their mental capacity. Mental capacity assessments had been made for each decision. It was not always clear when a person lacked capacity, and when a best interest's decision had been made, who had been involved in the decision-making process. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- At this inspection, no improvements had been made. People's care plans contained conflicting and confusing information about their mental capacity. Mental capacity assessments had been undertaken; however, they were not always clear about what the decision being assessed was. It continued not to be

clear when a person lacked capacity, and when a best interest's decision had been made, who had been involved in the decision-making process.

- Where people had a DoLS authorisation, this was not detailed in their care plans. This meant staff did not have the information they needed to understand people's legal status and make sure their rights were upheld.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The management had oversight of DoLS to monitor when DoLS were due to expire, when DoLS applications were required and what conditions were in place for people that had conditions on their DoLS.

Staff support: induction, training, skills and experience

At the last inspection in February 2022, the provider had failed to ensure staff had the appropriate training to ensure people's needs were met. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- At this inspection, a programme of training was underway. Most staff had received training relevant to meeting people's assessed needs such as epilepsy, diabetes, catheter care, learning disability, mental health and food hygiene. Some newer staff who had started 2 weeks before the inspection had not yet completed any training courses.
- The management team had identified training for some staff that was overdue, this included fire drills. Actions were being taken to address this and some staff were involved in a fire drill during the inspection.
- Staff received effective support and supervision for them to carry out their roles. Staff were supported to undertake qualifications in relation to their roles. Most staff told us they felt well supported by management team.
- New staff were supported to undertake the Care Certificate if they had not already completed this or a relevant health and social care qualification. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

- At this inspection, people mainly gave us good reviews about the food. People told us, "The food is nice. I am diabetic and the staff support me with my diet. I don't eat between mealtimes"; "We have a choice of 2 meals at lunchtime, and if we don't like the choice we can have a sandwich or something else. I like the fish and chips they make here, with tartar sauce"; "I like the stews we have here" and "The food is very good. There is always a choice."
- Meals were served in different rounds/sittings. This enabled staff to support people who needed support to eat first. People who were able to eat independently had their meals at the next sitting. One person who had their meals at the second sitting told us, "my vegetables are often quite cold, I eat in my room." We fed this back to the management team so that this could be improved.
- Mealtimes were relaxed and people were supported to have meals that met their needs. We observed in one area of the service that people had all been brought to the dining room together. This meant people at

the second sitting sat and observed 2 people who were at the first sitting eat their meals. Most people living in the apartments received their meals from the main kitchen.

- Communal kitchen areas had been refurbished, these were clean and well stocked. At this inspection, all opened food was labelled and in date.

Adapting service, design, decoration to meet people's needs

- At this inspection, maintenance tasks were observed to be completed in a timelier manner. A redecoration programme was still in place and some rooms were already complete. People's rooms had been decorated and furnished to their own tastes. One person said, "I have been told by [registered manager] about personalising my room, I choose to have it plain."

- At this inspection, the provider was in the process of replacing furniture in the service.

- It is evident that people know their way around the service and were seen actively finding their way to lounges, dining rooms and their bedrooms as well as outside. There was dementia friendly signage in place on the top floor of the service. However, way marking around the service was not in place, despite some people living with dementia. We observed one person tell staff they get confused as to where they are and which way their room was.

# 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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

At the last inspection in February 2022, people were not consistently receiving good care. People were not always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10. However, there were some areas for improvement.

- At this inspection, although some improvements had been made in the service, these were not fully embedded or consistent across the service. This meant people were not consistently receiving good care.
- People were not treated with dignity and respect when they experienced delays to being provided laxative medicines when they were in discomfort. People were not well treated and supported when they had not received medicines they were prescribed and staff had not monitored their bowel motions to make sure they were not constipated.
- People's needs were not always respected. People's deterioration in health had not always been identified.
- Despite the concerns above, people told us, "We all think a lot of our carers here, they are all nice and wonderfully caring"; "The staff are alright. Some of the staff are happy. Some of them are miserable and I cheer them up. They are respectful and ask me before they do personal care"; "The staff are friendly"; "The staff are friendly and outgoing"; "The staff are all friendly. I think they know what I need done"; "I like the carers that I know"; "The staff listen to me, they would know about it if they didn't" and "The staff are friendly and kind."
- A relative told us, "The staff are relaxed, personable and professional. I am impressed, he's come out of his shell and has improved. They are committed to their clients. It is the happiest he's been in 2 years. He is in the place he needs to be, they get him up, showered and dressed, the positive is he's now enabled to socialise and he's up and about." Another relative provided written feedback; '[Person] can't talk but the staff recognise her indications of how she feels and what she wants. This means everything to me as I can be assured that [person] is happy and content.'
- We observed some good interactions between staff and people, which showed that staff knew people well, knew how to communicate with them and helped the inspection team communicate with people.



- People were able to spend time with their relatives in their own bedroom as well as communal areas. We observed staff knocking on doors before entering people's bedrooms and checking with them it was ok to enter. This included when people's doors were open. One person told us, "Staff knock on door before coming in. they are good at closing curtains as I'm near the front door." Another person said, "I have a knocker on my door and they knock before they come in, and ask before they do anything."
- Staff discreetly asked people if they were in pain and wanted pain relief during medicines administration rounds. Staff discreetly checked with people to see if they wanted assistance to go to the toilet.
- Staff told us they ensured people's curtains and doors were closed when they supported people with their personal care. Staff said they protected people's dignity by covering people up with towels when supporting people to wash and dress. One person told us, "The staff are kind and respectful. They cover me with towels when they have undressed me for a wash. They ask me if I want to do my own personal bits."
- People were supported to be as independent as possible. For example, people were encouraged to carry out personal care tasks themselves on areas of their bodies that they could reach.
- People's personal records were stored securely in the office. People's personal records were also stored on computers and applications on smart phones, these were protected by passwords. Information held at the office was locked away as necessary in a secure cupboard or filing cabinets. Computers used by the provider and staff were password protected to keep people's confidential information secure. Applications on mobile phones were password protected, so that only staff who had been authorised to access the information could do so.

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

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

At the last inspection in February 2022, care and support plans were not always person centred and were inconsistent. The failure to design care and treatment to ensure people's preferences and needs are met was a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- At this inspection, the provider did not have systems and processes in place to ensure that care plans were developed in a timely manner to ensure staff had clear information in order to meet people's needs. The provider had policies in place which set out that care plans would be in place and set out timescales for these. However, systems were not in place to check that adequate actions had taken place. One person had lived at the service for 2 months and had no moving and handling assessments and no care plan. The person's pre-admission assessment had not been used to put a care plan in place and had not been reviewed and updated as the person's needs had changed. This meant staff did not have all the information they needed to provide safe care.
- Care plans were not always in place to detail how to provide care and support. Where care plans were in place these were not always detailed enough to evidence people's care and support needs. We reviewed care plans for 2 people, who lived with a learning disability did not have goals and information for staff about how they could achieve goals and aspirations. The care plans did not follow Right Care Right Culture Right Support guidance which is national guidance for supporting people with learning disabilities.
- One person's care records detailed they had epilepsy, however there was no care plan or information about how staff needed to work with them and what action they should take if the person had a seizure.
- One person's care records evidenced they were self-caring with daily washes and personal hygiene. The care plan stated that staff should support them by prompting them to have a shower, however records did not evidence that this had happened. There was no record that staff had offered to support the person with a shower or that the person had declined. The person told us they had not showered for years.
- Nail and hand care had not always been embedded into peoples' routine care and support. On 4 January 2023 we observed three people with very long fingernails. One person's nails were also dirty under the nail. Two of the people had contracted hands who required support with nails to avoid injury from fingernails digging into their palms. This has been a consistent issue at the last 3 inspections. During the inspection people received some support from staff to address this, we observed staff knocking on doors after we had

identified issues with nail care offering to file nails.

- Oral care has not always been embedded into people's routine care and support. On 4 January 2023, we observed 2 people with visibly poor oral care. One person was cared for in bed. Their teeth were not clean. We checked their ensuite, there was no toothbrush visibly present. The person told us, "I don't remember how often I brush my teeth. I don't think it is every day." After the inspection the provider told us, the person's toothbrush was in a drawer under the sink. It was clear from our observations the toothbrush had not been used that day.

The failure to design care and treatment to ensure people's preferences and needs are met was a continued breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

### Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were known and understood by staff. People's support plans included details which helped new and unfamiliar staff learn about how people expressed their needs.
- Information was shared with people and where relevant, available to people in formats which met their communication needs. There were some visual aids around the service, for example informing people about complaints, staying safe from abuse, COVID-19 safety, social distancing guidance, menu's and activities.

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

- The provider had an activities coordinator in place and some activities were taking place during the inspection across the service. The activities coordinator tried to ensure that they planned different activities with people based on their feedback. Sometimes activities were rescheduled due to lack of equipment. For example, if a baking activity had been arranged and the ingredients had not been purchased. Staff told us sometimes activities had been rescheduled due to staff shortages.
- The activities coordinator spent time liaising with people living in the bungalows and apartments to let them know what activities were on offer and encouraged them to join. They tried to spend time with people who were cared for in bed and those who chose not to join in with group activities.
- We observed some people going out into the community on their own if they were able to and with family members. On one of the days of inspection, some people were supported to go out shopping at a local supermarket and have a hot drink whilst they were out. We observed staff in the annex area of the service supporting people to play games using an interactive games table. People were smiling and appearing to enjoy it.
- People fed back that they would like more activities staff to support with activities across the service. People told us they would like support to go on trips. Comments included, "Trips out, we don't do any. We had some Christmas parties; they were good fun"; "I don't feel well to join activities. I have a smart phone, have internet access, I listen to radio 4 day and night"; "I like the TV. I'm not one for activities, I prefer a quiet life, I have a phone and tablet, I can stay in contact with family"; "I do the activities in the home, music and games. I go out shopping using the minibus. I go out on the sea front. I would like to go out more than I do at the moment"; "I am content here. The wi-fi is working okay and I can do video calls with support, to my family"; "I go out with my mum and sister when they visit. I would like to do some cooking" and "I would like

to do more activities, go to the cinema." After the inspection the provider told us, "There are several support staff who assist with activities. This includes driving a minibus to take people on days out or on community trips."

- Relatives said, "Activities and stimulated events are lacking in the home" and "I take her out each week when I come. Staff told me they offer to take her out and she says no. [person] says they haven't asked her. They could do with another activities person to help get people out more."

### Improving care quality in response to complaints or concerns

At the last inspection in February 2022, the provider had not followed their complaints processes when responding to complaints received. The failure to acknowledge, investigate and take action in response to complaints was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16. However, further improvements were required.

- At this inspection, records showed complaints received had mostly been responded to and resolved satisfactorily. The complaints policy was on display. One person had complained in a survey which they had completed. The complaint had not been detected in the survey and so had not been responded to or actioned. This is an area for improvement.
- People and their relatives told us they would complain to the staff or the registered manager if they were unhappy about their care. Comments included, "If I had a problem I would speak to the head of the unit or the manager"; "I would talk with [registered manager] or the girls (staff) if I had a problem or wasn't happy" and "I would report any issues to the office. Sometimes they direct me to the floor manager."

### End of life care and support

- Most people living at the service had not been asked their wishes, thoughts and preferences in relation to their end of life wishes should they become unwell or have a serious/unplanned medical event. This is an area for improvement.
- The service was not actively supporting anyone at end of their life. A person was reaching the end of their life and had been prescribed anticipatory medicines and their family had provided information about end of life care and wishes. Most staff had received end of life care training. We were not assured this had given staff all the necessary information and guidance they needed as staff had not always recognised when people were at the end of their life.
- Some people had consented to DNACPR (do not attempt cardiopulmonary resuscitation) with their GP or consultants.

# 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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. 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; Continuous learning and improving care

At the last inspection in February 2022, the provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. There was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- At this inspection, the provider had failed to ensure robust and sufficient systems were in place to audit the quality of the service to alert them to concerns and issues within the service. Audits had not picked up significant shortfalls in practices in relation to risk assessment, accident/incident monitoring, medicines management, safeguarding concerns, meeting people's health needs, capacity and consent, care planning, accuracy and integrity of records.
- Audits undertaken were not robust. Mattress audits appeared to check the same mattress and same room number rather than a full check of mattresses in each of the units within the service. This meant the provider could not be assured that all mattresses in the service were functioning correctly, met infection control guidance and were safe to use.
- Continence audits were not robust. A continence audit had been carried out on one person on 12 October 2022. The audit was not robust and had not checked their bowel charts and fluid intake. Had the fluid output charts been checked they would have identified that the person may not have been having enough to drink as output was low or non-existent. The bowel chart for the person also identified that they were frequently constipated and not opening their bowels (which was a known trigger to their epilepsy).
- Nutrition and hydration audits were not robust. The audits did not check that people had drunk enough to stay healthy. One person's fluid charts showed that they had not drunk enough in the 2 weeks leading up to the date of the audit.
- Medicines audits were not robust. The medicines audit conducted on 30 November 2022 identified that there were no concerns with controlled drugs (CD) records. However, our findings showed there were issues with CD records at that time. The medicines audit completed in December only detected a small amount of issues with medicines and had not detected what we found during the inspection.

- People were at risk because registered persons had not acted to ensure they had sufficient oversight of the service. There had been a lack of provider and management oversight at the service which had caused issues with safe monitoring of practice and day to day management. Leadership at the service was wholly inadequate and placed people at risk.
- The 'resident of the day' system was still in place. This meant that when a person was the 'resident of the day' they had their care plan reviewed, bedroom deep cleaned, they discussed meals they wished to have and activities which were important to them. During the inspection it was clear this was happening for people. However, there were missed opportunities in the process to make sure every element of the person's care was reviewed and reassessed to make sure all care plans and risk assessments were in place.
- Records were an area of concern across the service. Records were of poor quality and did not include a complete and accurate record of care provided. Throughout the inspection staff told us that records were not correct. For example, one staff member stated that one person's bowel charts were incorrect as they had definitely opened their bowels since the 30 December. However, the bowel charts and daily records for the person did not detail this had happened. Another staff member told us that a person's blood sugar levels were recorded twice a day, however these had not been recorded on the person's blood sugar monitoring form or in their daily notes. Incidents of anxiety, distress and aggression were not always recorded when these happened.
- Records continued to be an area of concern after the inspection. A notification of an incident that had occurred was factually inaccurate, we raised this with the management team. The registered manager agreed that it was incorrect, and a new version of the notification was sent. Safeguarding referrals made by the service to the local authority safeguarding team were also inaccurate and did not include all the information of concern.

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

- The provider had systems in place to gain feedback from people living at the service. We found that some feedback had not always been responded to. Audits showed that one person had stated on 9 December 2022 they would like baths and not just showers. We checked their personal care records between 9 December 2022 and 12 January 2023. No baths had been recorded and there was nothing to show that the person had been offered a bath and declined.
- Another person had been moved to one of the bungalows. They told us in the inspection that the reason why they spent all their time in the main building was because they did not like it at the bungalow, and they liked to be around others and have company. We could not be assured that registered persons had explored or identified that the person did not wish to be in the bungalow and that was why they were spending their time in main building.

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our findings above, people and relatives knew who the manager was and told us some improvements had been made. Comments included, "I see the manager every day"; "I am impressed with the manager, she is on it when it comes to procedures"; "A noticeable improvement, the staff profile is more positive. The improvements are not rocket speed improvements. Feedback from [loved one] and staff is that the regime from [registered manager] is tough. I am pleased as [registered manager] keeps them on their toes."

- People were invited to regular meetings to provide them with opportunities to feedback about their experiences of living at the service. Minutes of meetings showed people were listened to, the management team had created a 'You said, we did' feedback board. People told us, "I have no complaints. I have been to residents' meetings. I asked if I could visit a museum. Nothing has happened yet, but I think that they will take me. I don't know how long ago it was I asked"; "We have a residents meeting about once a month. The staff take the meeting. We are asked beforehand if we have any questions. I needed to ask a question about my finances, and it was sorted" and "They do have residents' meetings, but I don't go to them, my choice not to go."
- The provider was in the process of sending out surveys to people, relatives, professionals and staff to gain feedback about the service. Some completed surveys had been received back with mixed feedback. Some had provided positive feedback and one had raised concerns about medicines management and missing laundry, the concerns had not been addressed and followed up in line with the provider's complaints policy.
- Compliments had been received from people, relatives and professionals. One professional wrote an email which stated the person they worked with received 'Fantastic care and support' at the service. A relative wrote to us and stated, 'I am very happy with the care [loved one] receives.'

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

- The provider had not acted to develop and embed a culture of respect and inclusion for everyone. Staff gave us mixed feedback about the culture, some said that it was an open and honest culture and they felt well supported. Others told us the culture was not open and honest, they described a culture of bullying and repercussions if they raised concerns with the management team. Some staff did not feel listened to.
- There was more structure to the management of the service, a daily meeting took place with the registered manager and staff from each area of the service, this included maintenance, kitchen, housekeeping, activities, administration and care. This enabled better information sharing, staff were involved in developing appropriate actions to problems that cropped up. However, there were missed opportunities in the meeting to gain oversight of people's continence, nutrition and hydration and review accidents and incidents.

Working in partnership with others

- The service worked in partnership with people, their relatives and health and social care professionals. Relatives told us communication had improved. Comments included, "Communication has been good" and "They do tell me if there are changes." However, feedback from a health professional was that the service was reactive rather than proactive in identifying changes to people's health, which was not helpful to effective partnership working.
- The registered manager had taken the opportunity to attend video link local forums and local and national events to liaise with others and keep up to date with good practice. This included local infection prevention and control provider and manager networks, which they had found useful.
- The management team had maintained contact with local authority commissioners, quality assurance teams and staff as well as health care professionals such as GP's, district nurses and consultants. Feedback with the GP was not always in a planned way which meant the visiting healthcare professional did not always know who they were seeing as part of their weekly visit and why. We discussed this with the management team during the inspection and they implemented a system to alert the GP surgery in advance of who needed to be seen and why.

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

- It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service

where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their rating in the main entrance to the service and on their website.

- The registered manager understood their responsibilities to ensure compliance in relation to duty of candour. They had written to people to apologise when things had gone wrong. Duty of candour is a set of specific legal requirements that service providers must follow when things go wrong with care and treatment.