Marcus Care Homes Limited

Enstone House

Inspection report

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Date of inspection visit:
13 February 2020

Date of publication:
15 April 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

About the service
Enstone House is a residential care home registered to provide accommodation and personal care to up to 36 older people living with dementia. There were 31 people living at the service at the time of the inspection.

People's experience of using this service and what we found
People did not always receive care that was personalised to them. Where people had support with personal care it was planned to be delivered in an institutionalised, regimented and a structured way.

People did not always receive care in a dignified manner. We observed staff using inappropriate and undignified language when speaking with people and in people's care plans. Staff reported being tired, overworked and told us as a result, they were "snappy" with people.

People were not always protected from risks surrounding the environment. We observed cleanliness and malodour concerns at the service and found people were not always protected from risks surrounding the environment.

People commented there was the lack of activities of their choice, there was no evidence activities provision planned considered people's life history and individual wishes. Staff had poor understanding of dementia including how to manage people's distressed behaviours. A staff member referred to people's behaviour that may challenge as "violence". This was derogatory and labelling.

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

The registered manager reported safeguarding concerns where required. However, staff were not always aware of the importance to follow the provider's safeguarding policy. Where risks to people had been assessed the guidance on how to manage these risks was not always current and did not reflect where people's needs had changed. There was no evidence accidents had been audited for trends and patterns, to prevent reoccurrence and establish lesson learnt.

The systems to monitor and improve the quality of the service deteriorated further. Where a feedback from satisfaction surveys had been gathered or an area for improvement identified, these had not been actioned effectively. There was no evidence of the provider's overview of the quality of the service at Enstone House.

Staff reported they were not valued and there were low staff morale. Comments from external professionals reflected staff were kind but the environment and the management were poor.

People's dietary needs were assessed, and people were encouraged to eat well. and meet their healthcare needs. People had their medicines as prescribed.

People's privacy was respected, and people's relatives were positive about the care at the service.

Rating at last inspection and update:
The last rating for this service was requires improvement (published 23 March 2019). At this inspection we found not only no improvement had been made, but we found further concerns and the provider was found in breach of regulations.

Why we inspected:
This was our scheduled, planned inspection based on previous rating.

Enforcement
We have identified five breaches in relation to the management and governance of the service, dignity, safety, person-centred care and need for consent. You can see what action we have asked the provider to take at the end of this full report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

More information is in detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Enstone 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 two inspectors and one 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
Enstone House 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, who was registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced and took place on 13 February 2020.

What we did before the inspection
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. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We also reviewed the last report and contacted the commissioners to gather their views.

During the inspection
We spoke with 10 people who used the service, three relatives and one visiting professional to get their views

about their experience of the care provided. We also spoke with 8 members of staff, including the registered manager, two senior care staff, four care staff and the activities co-ordinator.

We reviewed a range of records. This included three people's care records and samples of people's medicine records. We looked at two staff files in relation to recruitment and staff's supervision and training records. A variety of records relating to the management of the service, including complaints, accidents and audits were also viewed.

After the inspection
We contacted six external professionals to gather their views about the service.

Requires Improvement

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 Good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

● People were not protected from risks of cross infection as the environment was not clean, hygienic or free of unpleasant odours. For example, there was a malodour in the corridor that appeared to be coming from the shared toilet. A staff member told us, "Yes, the [person] from room [room number] uses it and 'goes' everywhere. I don't think cleaner been up yet, as it is only one cleaner on and she starts (cleaning) downstairs (first)". Following our intervention, the toilet was attended to.

● We observed a hoist and a foldable privacy screen in a corridor. A sling was thrown over the hoist and a book and a clothing hanger was tucked underneath it. The layer of dust covering the equipment suggested it had been left there for a considerable time. We raised this with a staff member who told us, "Cleanliness? Much to be desired, (home) needs a bit of scrubbing". Another staff member told us, "Some days we have no cleaner".

● We also observed cleanliness concerns in people's bedrooms and feedback received confirmed our findings. One relative said, "[Person's] room wasn't clean earlier in the week and I think they are bringing in another cleaner. The bathrooms are sometimes not clean".

● External professionals told us they observed cleanliness concerns and the service was "Not as clean as it should be".

Assessing risk, safety monitoring and management

● Risks surrounding people's conditions, such as their mobility or falls had been assessed and recorded. We however found the records had not always been updated when people's needs changed. For example, one person's risk assessment stated, "Encourage to use lift to go to and from bedroom, one staff to assist. Ensure [person] uses walker when mobilizing and (it) is easily accessible". This risk assessment had been reviewed monthly. This person's equipment care plan stated as from April 2019 the person no longer mobilized independently and required a hoist and an assistance of two staff with all transfers. This meant the records contained contradicting information and this could put person at risk of not receiving safe care.

● There was not always evidence kept to show risks to people were being monitored. One person suffered a fall and the accident form stated the person, "Banged head on the floor." As a result of the fall the person sustained a cut to their eyebrow. The form stated, "For the next 24 hour, monitor for dizziness and sickness". We asked the registered manager for the evidence of these checks and they said, "We don't document it".

● People could be at risk of delayed evacuation as there were no evidence fire drills took place. There was a fire risk assessment carried out by an external company in January 2019. A fire procedure attached to the document stated, "Full records of fire precautions is kept, this include fire drills". We asked the registered manager about the evidence of the fire drills and they said, "No records kept".

● The registered manager ensured some checks, such as flushing of unused water outlets and shower heads

cleaning took place. However, the most recent Legionella risk assessment carried out in 2016 stated that water samples should be tested for Legionella every six months. When we asked the registered manager about it, they said, "None done since then".

The systems to manage safety were not effective and could place 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.

Systems and processes to safeguard people from the risk of abuse

● We saw safeguarding concerns had been appropriately reported to the local authority when needed by the registered manager.

● We however found staff did not always understand the importance of reporting the concerns. We asked staff what would do if they had been made aware of a poor practice. One staff member said, "I would prefer to speak to my colleague face to face". When we asked about reporting to the management, they said, "I don't like it this way". We checked with the member of staff if they had safeguarding training and they said, "Yes, we had safeguarding training, lots of papers! I think I understood it correctly but I would not follow it as it's not to my belief". This meant we could not be reassured staff would promptly report any wrongdoing.

● People told us they were safe at the service. One person said, "I'm as safe as anyone can be".

Staffing and recruitment

● We received mixed feedback from people and relatives about staffing. It included, "Sometimes there aren't enough (staff), they are just rushing about all over the place", "It depends on the day – it's alright I suppose. I do feel rushed if they want me to go and eat, come on, come on, they say" and "There is always someone around."

● Staff told us there were not enough staff. Comments from staff included, "Some carers work several long days in a row, it is not safe", "We had night staff leave and we've been short for a couple of months" and "Some residents are neglected because of the lack of staff".

● Staff said the planned staffing levels had not always been achieved. One staff member said, "I am so tired now, worked three long days in a row, staff do call sick and we're short, like last Sunday, if we had six staff like we should it (would be) OK but that doesn't happen".

● The provider followed safe recruitment practices when recruiting new staff.

Learning lessons when things go wrong

● There was a lack of system to monitor accidents, we saw accidents summary that listed the accidents that occurred each month, however, there was no information recorded what if any preventative action was taken to minimise the risk of the reoccurrence or if any trends or patterns were identified. There was no evidence of improving practice as a result of it.

● The provider did not ensure lessons had been learnt. The findings at this planned inspection demonstrated not only no improvements had been made since our last inspection but further decline in practice was found.

Using medicines safely

● People received medicines as prescribed. Medicines were stored safely and securely.

● Staff who administered people's medicines were observed to follow good practice guidance. This included dispensing, cross checking, administering and then signing the records once the medicine had been taken by a person.

● People were encouraged to take their medicines if needed, for example with 'when required' medicines, such as the medicine to aid with bowel movement.

Requires Improvement

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 Good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● People told us their choices were not always respected. One person told us staff did not always respect their choice of clothing. Other people said, "I don't like being told what to do" and "Am I an individual here? I think that's pretty superficial. I don't think anyone here understands us." One person's relative told us the person would prefer to stay in their bedroom as they found it too noisy in the main lounge, but staff wanted the person to be in the main lounge where they could see the person. They said, "It's noisy outside and they don't really let you come to your room during the day."
● Feedback received from staff demonstrated staff did not always work in line with the principles of the MCA. One member of staff said, "Especially for people who have strong level of dementia we need to choose for them as (we) can't wait for their consent".
● There was no evidence where decisions had been made for people it was done in line with the best interest principles. For example, one person's file stated the person's family had been informed about their move to another, shared bedroom. This person's file also stated the family 'has been informed' about the person having bed rails. There were no capacity assessments surrounding these decisions. This person's file clearly stated the family had no legal authority to make these decisions for the person. The registered manager applied for DoLS for this person however the capacity assessment surrounding their residency related to the person's previous accommodation.
● Another person's care file contained a capacity assessment which said, "Has capacity to make own decisions. A DoLS is not required as has got full capacity". This showed a poor understanding of the MCA Code of Practice. We asked the registered manager if they were able to show us an example of a file where

the best interest decision had been followed correctly and they said, "I probably haven't done best interests forms for anyone".

This meant people's consent was always sought in line with the good practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff received training in areas deemed mandatory by the provider. A staff member said, "I don't have problem with training". People and relatives commented staff appeared trained. Comments included, "There are different levels of staff and the more senior ones seem to know a bit more" and "We think the staff are pretty good."

● In the afternoon we observed a distressed person tried to go out of the building. Staff were observed to contradict the person's views of why the person felt they needed to leave. Another member of staff tried to help, and both staff tried to move the person away from the door. It was distressing for everyone, including the person who was clearly very upset and anxious. The registered manager said this happened every afternoon at about the same time. Despite this being a predictable reoccurrence, no prevention distraction techniques were used. Despite the service predominantly caring for people living with dementia only basic dementia training had been provided to staff. A staff member said, "We haven't done any specialist dementia training course, dementia training is booklet based". Another staff member said, "I think it should go into more details". We asked the registered manager if any training surrounding the management of distressed behaviour had been provided to staff. "Not for that" was their response.

● An external professional told us, "Staff don't seem to grasp the reasons for people's behaviour. People's needs deteriorated over the time I've known the home, people's needs increased. The service struggles to meet people's advanced needs."

● The registered manager carried out staff supervision and samples of staff supervision we saw showed no discussion around staff's skills and their understanding of the courses completed took place. This was a concern as we found some staff's understanding of training completed was not always adequate.

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

● People were supported to maintain their dietary needs, their care plans stated what level of assistance people required. This included nutritional risk assessments where people were at risk of not eating well. Different coloured crockery was used to distinguish when people needed more assistance with their meals. We saw some people used plate guards to aid them eating independently.

● People were positive about the food but said they were not always given choice. Comments included, "I have the same breakfast every day, but I'm happy with that. The food is good", "I have breakfast in the lounge. I have to have what they tell me – porridge or Weetabix and toast. Lunch starts about 12, there's no choice. You can express a choice, but you don't get it! The food has gone down, there's not as much and it's not good quality. It's repetitious and not my style of eating" and "It's not home cooking but there's nothing wrong with it. There's no choice but I'll eat anything."

● We observed the lunch service. Some of the people who needed assistance had their meal first. They had pureed, or soft food where needed, and staff were observed to assist them patiently and skilfully. Then the remaining people who also needed assistance had help. People who ate independently were observed waiting a long time at the table, they were getting distressed and kept asking for food, but no explanation was given to them. There was no sense of urgency and we observed the registered manager saying, "The meal's been a bit delayed today, but it doesn't matter, there's no rush."

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

● Records reflected involvement of external health professionals, such as chiropodist, doctors and opticians.
● People's relatives also gave us examples of accessing health care, "There is chiropody here, and [person] has his hair cut here. His dentures have been replaced and a dentist has visited. The doctor comes every Friday. He has lost a lot of weight, but they are working to build this up and are monitoring his weight every week."
● Feedback received from external professionals was not positive. One professional said, "Manager not aware of prompt referral process, staff not always knowledgeable about reasons for referrals and people's needs".

Adapting service, design, decoration to meet people's needs
● There were some elements of dementia friendly décor, such as brightly coloured toilet door. We observed loud, modern music was played from speakers positioned throughout corridor and situated above people's bedroom door. This could be distracting for a person living with dementia as they would not understand where the voices were coming from. One external professional commented about the loud music that played from the speakers and felt it was not appropriate. Another external professional commented, "Kind staff, but the environment is working against them. Lack of separate areas for people. It's chaotic, noisy and disturbing.".
● People were able to personalise their bedrooms with own items.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed prior to admission to the service. Two relatives confirmed they were involved in the process. Comments included, "Yes, we were both involved. Manager assessed [person] in hospital and the home did a lot to make [person] welcome" and "We weren't involved but [person's] daughter was, I'm pretty sure a discussion took place."
● The information gathered included people's physical, emotional and communication needs, such as hearing or vision. This included oral hygiene good practice. We saw staff had training around oral hygiene and people's care plan reflected the level of assistance required.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always were treated with dignity and respect.

Respecting people's dignity

- Staff did not always use appropriate and dignified language when speaking with people. We observed a staff member made highly disturbing comments. This was meant as a joke but could add to people's distress. For example, one person was heard saying "I want to die." The staff member responded, "How fast – shall I strangle you or do something slower?"
- Staff told us that as much as they wanted to, they did not always feel able to provide dignified support to people. One staff member told us that they were 'impatient' with people. Another staff member told us, "You get tired and get snappy with residents, it should not be like this". This meant the provider did not foster a culture that valued people and supported a caring approach.
- People's care plans included terms such as "cot sides" and "nappy rash" which when used to describe needs of adults can be seen as patronizing and derogatory. A staff member referred to behaviour that may challenge as, "Violence" and they said, "Because they do get in your face, it's the dementia." This was labelling and showed a lack of understanding towards the people's complex needs caused by their progressive illness.

People did not always receive support in a dignified way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care. Promoting people's privacy and independence

- People's relatives felt people's independence was promoted. One relative said, "They respect [person's] wishes, he wants to be independent and doesn't like asking, he wants to do it himself and they try and let him." Another relative said, "They encourage [person] to walk, they keep behind her and let her do it herself."
- People were not able to give us examples of how they had been involved in their care and care plans. One relative gave an example how person's wishes were respected, "[Person] prefers male carers for their personal care and this is respected."

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

- People's relative were positive about the way people were treated and felt staff knew people's needs well therefore were able to meet their needs better. One relative said, "I think they know [person] well – they always deal with [person's] needs before they crop up, if you see what I mean." Staff said they wanted to provide good care to people. A staff member said, "I wanted to serve people, I like this work."
- People's individual needs, including diverse needs such as spiritual needs were met, there were visits by

the local vicar for people that wanted to participate.

● Staff knew people's needs in terms when people needed emotional support. For example, one person liked her favourite toy to comfort them and we observed the person had the item with them.

Requires Improvement

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 requires improvement. At this inspection this key question remained the same. 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.

● People did not always receive personalised care and support. For example, since our last inspection a bathing rota was introduced. It listed which person was to have a bath each day, on each floor. We asked one staff member and they said, "We only do baths in the morning". When we queried the reason, the staff member said, "I just accepted it as a rule of the home". We asked the member of staff what if someone liked, or wanted to have a bath in the afternoon, they said (referring to an incontinence), "If there is an accident, we clean with towel and soap. I think it's the time problem, too many things going on". This showed there was a rigid and an institutional approach.

● Our observations showed people did not always received appropriate support. We visited one person in their bedroom on the morning of the inspection. The person had just recovered from an infection. Their bedroom was stuffy which added to the risk of dehydration and there was no water by the person's bed. We also observed stale food left on the bed side table.

● We received mixed feedback from people and their relatives about the care at Enstone House. Comments included, "I'm very pleased with what they do for [person]" and "I can't say. I'm a bit anti because I came here against my will. It's not too much of a problem being here but they aren't on my wavelength and I'd rather be somewhere else."

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

● At our last inspection we found people did not always received meaningful social stimulation. At this inspection we found this still needed improving. On the morning of our inspection we saw the weekly activities calendar was left blank. Later we saw a member of staff writing the activities planned for the day of our inspection only.

● There was no evidence people's life histories were used to tailor activities to people's choice. One person told us, "I do nothing. After morning coffee, we are supposed to do activities but nothing much happens. I don't do pink balloons, it's so immature. I take part a bit because I feel I should but I'm not enthusiastic."

● People's care plans contained contradicting information about people's social inclusion. One person's care plan in 'hobbies' section said, "All clients are regularly offered the choice to join activities around the home". Another part of this person's care plan stated, "Prefers not to join activities around the home".

● People expressed their frustration about the activities provision. "I'd like to be able to go out", "I'd like to go out in the car", "I'd like to have somewhere where I can paint", "I'd like to have a dog" and "It's not my home" were some of the comments made to us. An external professional said, "There are always people who are just sat there, looking at wall." We received further, numerous comments that reflected activities needed improving.

● There were plans to introduce reminiscence boxes filled with items relating to each person and would be used to stimulate conversation with people.

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.
● We asked the registered manager how the service met AIS standards and they said, "I haven't done that". We saw people's care plans contained some information around people's communication needs. For example, "[Person] can become anxious if feels staff don't understand her."
● We received mixed feedback about meeting people's communication needs. One person said, "I'm deaf because I've lost my hearing aid, I need to talk to someone about it but they don't want to be bothered." Another person said, "I wear glasses, but I've lost them, so I can't see and I can't read. I need to see an optician, I haven't asked yet". One relative said, "There was a problem with [person's] teeth and that was sorted."

People did not always receive person-centred approach. This was a 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 and their relatives knew who to complain to if needed. Comments included, "[Registered manager] or the staff will always respond" and " I think [registered manager] is pretty good – I go to her and tell her about problems."
● There was a log of complaints and none had been recorded as received since our last inspection visit.

End of life care and support
● No people received end of life support at the time of our visit.
● Information about people's end of life wishes including their resuscitation status and future wishes was included in their care plans.

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 requires improvement. At this inspection this key question has now deteriorated 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.

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

- The provider and the registered manager did not ensure positive culture at the service. There was no credible vision or values at the service and staff reported high level of stress and work overload. Comments from staff included, "At the moment everyone is fed up. Everyone is sick of it all" and "Staff are leaving because of issues here." Staff also commented that there was a feeling of, "Constantly being rushed" and that the management were not encouraging.
- This had not gone unnoticed by people. One person said, "There are sometimes rows between the staff, we think it's quite funny, but they can be quite nasty sometimes to each other." This meant the leadership at the service did not create an environment that respected people's home.
- Staff reported there were divisions among the team, cliques and poor team work. A staff member told us, "Last (staff meeting) one we had, she (registered manager) just told us off for everything. We should have respect and not be snapped (at)." The samples of the meeting minutes we saw confirmed this feedback.
- Staff told us they did not feel valued and respected. Comments from staff included, "You come in (to work) and wonder what mood she [registered manager] is in" and "The home is not managed well, and nobody is happy and (we are) overworked." The registered manager said, "Staff morale are down at the moment".
- Additionally, staff expressed concerns of experiencing repercussion following them sharing their open and honest feedback with us. This meant staff did not always feel able to be open when things went wrong. It also meant the provider did not support transparency.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- There were significant and widespread shortfalls in the way the service was led. The standard of records and running of the service had further declined. We reported about numerous concerns found in each of four above domains. This included concerns around people's care documentation and the lack of contemporaneous records.
- There were poor systems to capture and manage organisational risks. When we asked the registered manager on the morning of our inspection what they thought of the quality at the service they said, "We're brilliant". Given the shortfalls we observed this demonstrated they were out of touch with what was happening at the service.
- The provider failed to evaluate and improve their practices. For example, by not ensuring staff had a good understanding of safeguarding or Mental Capacity Act. This meant there was a risk reporting of issues could be unreliable or inconsistent and that staff were not adequately supervised.

● There was a lack of effective audits. The registered manager's "Monthly House audit" for the entire twelve months of the previous year was in a form of a table that contained several headings, such as people's care plans, cleaning or health and safety. Each month a tick was marked to show the section was deemed as checked and compliant. This meant there was not only no evidence what specific areas had been audited but these systems remained ineffective.
● Where action had taken place, the registered manager failed to measure if it had been effective. For example, the above audit form showed the MCA training took place in December last year. Despite this we found significant issues in both practice and records surrounding the MCA.
● There was no evidence to reflect the registered provider had any form of overview. The registered manager said no support was provided to the registered manager to improve the service following our last inspection. It was particularly concerning as following the last inspection the service was rated requires improvement and we informed the provider good care was the minimum that people receiving services should expect and deserve to receive. This meant there was no evidence learning to improve practices took place.

Engaging and involving people using the service and the public, fully considering their equality characteristics
● The registered manager run relatives' satisfaction survey. We saw the summary results of the survey carried out in 2019 and noted that half of the relatives reported unwanted smells around the home. One of the action points made in response to this, stated 'There will be additional cleaner employed after the new year'. We found concerns around cleanliness and malodours on the day of our inspection. This meant issues had not been taken seriously and acted on effectively.
● People's relatives were consulted about people's care plans reviews.

Working in partnership with others
● Staff worked in partnership with the local health and social care professionals as needed.
● External professionals' feedback we received was negative and included, "I would never allow myself or my mother to be a resident here".

Due to poor governance of the service people were placed at risk of not receiving good care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● People's relatives said they were involved as required.
● The Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager was aware of her responsibilities and kept people's relatives informed as required.

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 The provider failed to ensure people received person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people had dignified support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure need for consent requirements were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were protected from risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure good governance.