Osmaston Grange Care Home Limited

Osmaston Grange

Inspection report

5-7 Chesterfield Road
Belper
Derbyshire
DE56 1FD

Tel: 01773820980

Date of inspection visit:
12 October 2016

Date of publication:
06 April 2017

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

This inspection took place on 11 & 12 October 2016. The first day was unannounced.

Osmaston Grange did not have a registered manager. The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is registered to provide accommodation and nursing care for up to 80 older people. On the first day of our inspection 68 people were using the service.

The provider did not have effective systems in place to ensure people were protected from the risks of cross infection.

Risk assessments and care plans did not always contain sufficient information to ensure people were cared for in a personalised manner. There were not always up to date and did not contain sufficient information for staff to care for people. Where care plans and risk assessments were in place, they were not always up to date or accurate and not all risks to people's health and safety were identified and where possible reduced. People had access to healthcare services however, people sometimes experienced delays to receiving their treatment.

Audits and systems designed to check on the quality and safety of services people received were not effective at identifying shortfalls in the quality and safety of services. Records were not complete and did not accurately reflect people's needs and wishes.

Staffing arrangements had not been calculated based on meeting the needs of people using the service. Staff were not always deployed in a manner so that people received timely support. Staff recruitment practices had not recorded how gaps in staff employment histories had been considered satisfactory. Some references had not been taken up.

The proper and safe management of medicines were followed and therefore risks associated with medicines were reduced. Records supported that people received their medicines as prescribed.

Staff training was not always up to date and therefore did not equip staff to care for people effectively. Not all staff received supervision on an individual basis and did not feel supported by the management structure in the service.

The principles of the Mental Capacity Act 2005 (MCA) were not fully understood and embedded in the service, nor had the principles of the MCA been followed for people's decision making. The service did not

assess people effectively for Deprivation of Liberty Safeguards (DoLS) applications.

People and staff did not feel listened to and we found people were not always invited to contribute to improvements at the service. Staff interactions with people were mixed. We saw some staff always spoke with people as they walked past, however other staff gave no greeting or acknowledgement to people.

Staff were not always given support when they raised issues of concern and safety. People did not have opportunities to pursue their interests and hobbies and some did not have the opportunity to take part in activities organised by the activities coordinator.

Not all people were supported to dine in a stimulating dining environment. Menu choices offered a balanced and healthy diet, however we saw not all people ate their meals and this was not always monitored effectively.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspection is added to reports after any representations and appeals have been concluded.

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.

People were not protected from risks of unsafe care. There were no effective systems in place to ensure the service was hygienically clean and protected people from the risk of cross infection. There was not enough staff on duty to keep people safe and to meet their needs and wishes. . Recruitment processes in place did not complete all pre-employment checks fully as required.

Is the service effective?

Requires Improvement

The service was not effective.

A high number of staff did not have the training the provider considered necessary to care for people. People's access to other healthcare services was not always made in a timely manner. The principles of the MCA had not always been applied, and people were not always assessed appropriately in relation to Deprivation of Liberty Safeguards (DoLS) applications.

Not all people were supported to dine in a stimulating dining environment. Menu choices offered a balanced and healthy diet

Is the service caring?

Requires Improvement

The service was not consistently caring.

Dignity not always promoted. Some people lived in unhygienic conditions that detracted from their dignity. People's privacy was not always protected.

Not all staff greeted or acknowledged people seated in communal areas as they walked past. Some people felt listened to, however people had not always been involved in opportunities to improve the service.

Is the service responsive?

Requires Improvement

The service was not responsive.

The service was not responsive.

Care planning was not inclusive and care was not personalised. People's personalised histories were not recorded. People were not supported to pursue hobbies and interests and most were left unstimulated.

There was a complaints process in place.

Is the service well-led?

Inadequate

The service was not well-led.

Systems designed to check on the management, quality and safety of services people received were not effective. Records were not complete and none of the areas we had concerns about were not picked up and acted on. The provider had not fulfilled their responsibilities to send statutory notifications about events that they are required to tell us about.

Osmaston Grange

Detailed findings

Background to this inspection

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

This first day of this inspection was unannounced. The inspection took place on 11 & 12 October 2016. On the first day the team included two inspectors, one specialist professional nursing advisor and one expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of service. On the 12 October the inspection team included two inspectors and a specialist advisor.

We spoke with the local authority and health commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

We spoke with six people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with seven relatives of people who used the service. We spoke with 13 members of staff, including care staff, domestic staff and the acting manager and the area manager.

We reviewed six people's care records. We reviewed other records relating to the care people received. This included some of the provider's audits on the quality and safety of people's care, staff training, recruitment records, medicines administration records and minutes of internal meetings.

Inadequate

Is the service safe?

Our findings

In February 2016 we inspected Osmaston Grange Care Home and identified a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. An action plan was submitted and the provider assured us the people who used the service would be protected from the risk of infection due to unclean premises by the 31 August 2016. The provider did not meet these actions.

The provider did not ensure people were protected from avoidable harm because all areas of the service were not hygienically clean. For example, in the area of the service where people living with dementia were cared for, the carpets in the dining room and corridors were very stained with ingrained dirt. The seats people were using in the same area were also dirty with ingrained dirt and worn to an extent where they could not be reasonably cleaned. The tables provided for people to eat their meals had pieces of veneer missing therefore were no longer wipe clean. This meant there was no means to render them hygienically clean. This put people at risk of infection.

The entire communal area of this part of the service and at least three rooms malodourous with odours that could be associated with urine. The lavatory near the dining room was malodorous and had several areas where the floor surface had eroded thus making it difficult to render it hygienically clean. The sink in the kitchen used to provide drinks and snacks for people was stained and encrusted in a substance that could be lime scale. This mean it was not hygienically clean and put people at risk of cross infection.

The provider had no effective cleaning systems in place in the service. Domestic staff chose their own hours to work and worked from Monday to Friday mornings only. This left the service without staff to clean on Saturdays and Sundays and every afternoon. There were no effective audits of cleaning or action plans in place to identify areas of the service that needed deep cleaning. This lack of care in ensuring the environment was clean left people open to the risk of cross infection.

When we showed this area of the home to a senior member of the management team they agreed it was not at an acceptable standard for people to live in and agreed they would not sit in the seats themselves.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It should be noted that some area of the service appeared clean and fresh and had been re-decorated. People living in this area were happy with the cleanliness of the service. However staff told us that most areas of the service were not cleaned over the weekend.

The provider did not have effective risk assessment processes in place to keep people who use the service and staff safe from the risk of harm. Staff told us they did not feel safe. A staff member said "One resident petrifies me, I told the manager, nothing was done, I've been chased by [person] and had to lock myself in the office, [person] just scares me". However one person said, "I feel safe here at night."

We saw records of these incidents where staff were attacked and in some cases sustained injury. They said they put themselves at risk to ensure people were safe. There was no evidence the provider had fully investigated the incidents and put risk reduction actions in place.

The risk assessments we looked at were very basic and did not contain adequate information on people's risk. There were no directions to staff on how to keep people and themselves safe. For example, three people expressed behaviour that presented challenges to the safety of people and staff. However, the risk assessments in place did not address these risks and give staff direction on how to mitigate the risk. One risk assessment said staff should use distraction techniques. These techniques were not explained. Staff we spoke with had no idea what the techniques were.

There were no other details provided to staff in a risk assessment on how to best support this person and how to minimise any behaviour that challenged. Notes showed that staff had stopped reporting incident to managers as nothing had been done to make them safe. One staff member said "What's the point no one listens."

The service could not demonstrate it was managing people's behaviour safely as there were either no care plans or risk assessments in place or risk assessments were not accurate.

Where incidents or accidents occurred there was not sufficient investigation to ascertain why it had occurred or what was being done to mitigate the risk. Where there was an investigation the action plan did not demonstrate all reasonable actions had been identified to reduce the risk of a similar accident re-occurring. In addition, the investigation had not identified that a safeguarding referral was appropriate. There was a high number of incidents in one area of the service. The acting manager and the assistant director were not aware of the extent of these incidents and the effects they had on staff and people.

Staff were aware of and had training in recognising different types of abuse. They were able to tell us the procedure to follow and who to report abuse to. However they had not used this knowledge to report the risks people were living with in parts of the service. Failure to do this meant that people using the service were not protected by staff and staff were not aware of their duty of care to protect people by following recognised safeguarding procedures.
This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure there was enough staff on duty to keep people safe. We discussed our concerns with the assistant director and the acting manager. As a result of this, they put an extra member of staff on duty 24 hours a day to meet this need. This staffing need had not been identified by manager, the assistant director or the acting manager, therefore it had not been addressed prior to our visit. One person clearly needed one staff member to be with them at all times to be safe and to ensure other people and staff were safe. This had not been included in staffing calculations and consequently not all people and staff were safe.

Rotas we reviewed showed that there was not enough staff to meet people's needs. A review of rotas showed there were staff shortages in July and August 2016 both in the mornings and the afternoons. These staff shortages were not addressed and there were no processes to assess the impact of this on people's care nor was there an action plan to ensure this didn't happen in future.

All the staff we spoke with said there were not enough staff available to stay with people and support them to eat their meals in the dining room, support them in the communal areas in the morning nor to spend time

with people when they were distressed. We saw distressed people left unattended and when staff did attend them they did not have the skills to calm them or to understand their distress. When we asked staff about people's distress they were unable to identify any causes or how to assist them.

We discussed with the acting manager how they deployed staff using staffs' skills and staff numbers. They were aware the staffing levels needed to be reviewed and in the short time (one week) they were in post they had increased the staffing levels. They were also aware the staffs' training did not meet the people's needs but had not yet had the opportunity to review staff training needs. Some people told us they had to wait longer than they wished for their personal care in the mornings. The acting manager and the provider was not able to demonstrate that staff deployed had the right mix of competence, skills, qualifications and experience to meet people's needs.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment files showed that staff employed at the service had not always been subject to full pre-employment checks. None of the staffing records, where the recruitment had been carried out by the provider, had the required information. For example, one person did not have any references. Another did not have the required references. Staff who had been recruited by an agency contained all the required information. Also one person did not have a report from the Disclosure and Barring Service (DBS) to see if they had any information which might mean a person was not suitable to work in the home. The DBS is a national agency that keeps records of criminal convictions. We showed this to the manager who said they would address this as a matter of urgency and the person would not work until the DBS had been obtained. Other people had gaps in people's employment history the provider had not recorded how they had assured themselves of a satisfactory explanation. This meant that there was a risk people may have been employed who were not suitable to work with people that used the service, as the provider had not assured themselves of their previous working history.

People's medicines were administered safely and as prescribed by their GP. Staff had been trained to administer medicines safely. Medicines were stored appropriately within a locked cabinet. We looked at the medicines administration record (MAR) for two people and found that these had been completed correctly. There was a system to return unused medicines to the pharmacy. Protocols (medicine plans) were in place for people to receive medicines that had been prescribed on an 'as when needed' basis (PRN). Routine reviews by psychiatrist, community nurses, annual reviews by the GP and diabetic clinics were also evidenced where required.

Requires Improvement

Is the service effective?

Our findings

The provider was not always effective in responding to the requirements of The Mental Capacity Act 2005 (MCA). This 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The acting manager told us they had applied for one DoLS authorisation for a person living at the service. They were waiting to hear the result of the application.

We found the process to record decisions in line with the MCA where people lacked the capacity to consent to their care and treatment was not followed. For example, when we asked if a person who did not have freedom of movement, was protected by a DoLS, we were told they did not yet have a diagnosis, therefore they were unable to apply for one. This was not accurate. None of the staff we spoke with understood the MCA and their responsibility to people. This included senior staff.

When staff make assessments of a person's mental capacity, they have to have 'reasonable belief' they are acting in the person's best interests. They also have to take 'reasonable steps' to establish the person lacks capacity to make a decision and establish that the decision is in the person's best interests. We saw no evidence that these decision making stages had been considered and recorded.

Therefore the provider could not provide assurances that care and treatment was being provided in line with the principles of the MCA and that the decisions staff had taken were in the best interests of the people involved. Nor were they able to assure us that the lease intrusive interventions were assessed,

Only the newly appointed acting manager was able to demonstrate a confident knowledge of the MCA and DoLS. Other staff told us they were not clear on how to apply the MCA to people's care plans. This meant people's rights were not being upheld, and restrictions in care were not assessed to establish if they were lawful and proportionate.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure staff had received the training they considered necessary to care for people in a safe and effective manner. The training matrix supplied to us and discussions with staff showed some staff had no training and the training of other staff was out of date. For example the breakdown of staff in the residential area of the service showed six of the 19 staff listed had not completed the training the provider considered mandatory. Five of the 19 had not completed any training. In the area of the service for people who were living with dementia five of the 18 staff had received no training. This lack of training was reflected

in the poor and unsafe care delivered to people. This meant people using the service could not be sure staff were trained to recognise and meet their needs.

Care staff were unable to tell us if they received individual supervision. Few showed an understanding of the process and they were not provided with the opportunity to review their performance and to give their concerns. We observed some clinical staff practice did not follow the provider's policies and procedures and fell short of their expectations for quality and safety of services. The provider could not demonstrate staff received sufficient support and supervision to carry out their roles and responsibilities effectively as their practice fell below the standards expected by the provider.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People generally liked the food they were offered. One person told us, "[Staff] are so slow at bringing breakfast, it's cold." Food was taken from the kitchen to various areas of the service and staff did not use a recognised method, such as a 'bain marie', to keep food hot. Another person told us food was usually hot when it arrived, but it was occasionally cold.

Other people told us the food was good and this view was shared by some family members. One person told us there was a good choice of food at breakfast and said the food was, "On the whole good."

Some people we spoke with told us their preference to eat in their own rooms was respected. However we saw other people who were not able to tell us their preference of where they liked to eat. However no effort was made to ensure mealtime in the dining rooms was an enjoyable experience. People were served their food in a haphazard manner. This prevented people eating at the same time. We spoke to the manager about this and they were aware of the situation and it was an area they planned to address.

The ability of staff to assist people to eat varied. Some staff did this at the person's own pace and they were given the choice of whether to start with their vegetables or their meat. Other staff showed signs of boredom and did not try to connect with the person they were assisting.

People who needed a special diet such as pureed food were catered for. For example people needed a soft food diet had it served in a separate plate compartment. This made the food look more attractive and appetising. Where people could easily spill a drink, we saw drinks were provided in lidded beakers so as to reduce the risk of drinks spilling.

People who were at risk of malnutrition had their food and fluid intake monitored. However the nutritional input for the day was not always added up and evaluated on a regular basis. This meant the overall picture of people's nutrition was not monitored effectively and this left the person who was already identified as been at risk vulnerable to poor nutrition.

People we spoke with told us they had good access to other health services. They told us a GP called regularly and staff would call the GP if they were unwell. Another person told us an optician visited and had tested their eyesight. Records showed people had appointments with other specialist health professionals involved in their care. However daily notes showed that for some people, they had not always received external health advice in a timeframe that prevented their condition from worsening. This included people who displayed behaviours that staff did not always understand and therefore were without professional input to assist them address.

Requires Improvement

Is the service caring?

Our findings

One person said, "The staff are nice here." Another said, "There are nice people here, I like it." However, we found the provider did not always provide care for people in a manner that promoted their dignity, privacy and independence. For example, some people had to live in conditions that were not hygienic and this detracted from dignity. A foot care specialist was observed caring for people's feet in the lounge.

We observed that most people in the residential and nursing areas of the service were supported to maintain their appearance. However, whilst most people in the area of the service where people living with dementia were cared for had not been assisted to keep their clothes fresh after their meals, we found four people had spent the day in clothes that were stained with food, un-ironed and dishevelled.

Some people were in the sitting room in a state of undress, three people had no footwear and two were wearing pyjamas. When we asked staff told us that had they had spent the night sitting in the sitting room. There were no blankets or rugs available to make them comfortable or to ensure their dignity was preserved. This meant that people were not always supported to maintain their dignity in a timely way. People living in other areas of the service were dressed in a manner that promoted their dignity.

People who were living with dementia were not offered the opportunity to have access to fresh air. There was a patio area they could have accessed but this was overgrown and appeared to be used to store old furniture. Also there was a sharp drop to the patio that was not addressed through the use of a ramp.

Staff told us some people had not had access to fresh air for over two years. This meant their independence was not promoted and they were not given very basic choices about spending time outdoors. We over heard one person say, 'you are keeping me in prison.'

Some people told us staff treated them with respect and knocked on their doors before entering. One person said, "Yes the girls are lovely and kind and always ask what I want." Another said, "The girls are the best you could find, they always knock on my door."

Two other people we spoke with told us staff respected their wishes to spend time in their own rooms. However we found one person sleeping on their bed. They were sleeping on a bare waterproof mattress. We saw they removed the sheet and pillow from their bed. The reasons for not using the bedding had not been explored. But it was clear it was difficult to keep the sheet on the bed as it was very worn and very small barely big enough to cover the mattress.

Some staff were not always caring. We saw they passed people without acknowledging them or responding to people saying hello. We overheard staff refer to people in a manner that was childish for example we overheard staff mocking one person. "We are writing up about you we have so say if you were good. Were you good." The person was unable to answer.

There were periods of time people were sat with staff walking past them who offered no acknowledgement

or offered no greeting to them. Other staff were observed to tell people to sit down when they clearly did not want to. However other staff were very caring and some told us they were embarrassed and angry about the conditions some people were living in and said they felt deeply about this and had been trying to make improvements.

Relatives told us they were free to visit when they wanted and we saw people had visitors throughout the day. We saw that some relatives spoke with staff to ask questions about their relatives care and treatment and we saw that staff provided responses to these questions. Relatives were given opportunities to contribute their views about the care and treatment of their family members.

Requires Improvement

Is the service responsive?

Our findings

The provider did not have thorough systems in place that included people in planning their care. Therefore, care plans did not provide detailed information about each person's needs and wishes. Care plans had gone through format changes but were still not easy and useful working documents. Most of the staff we spoke with were unaware of the detail in people's care plans as they had not read them. One staff member said, "We don't have time to read care plans". This meant the staff relied on handover meetings and word of mouth for details about how to care for people. For example, when we asked one staff member if they knew [person's name] condition they were unable to tell us.

Most handovers were done verbally and did not always contain the level of detail and information we would have expected to ensure people's needs were met.

One person whose health had deteriorated moved within the service. This was not noted on their care plan and their previous history in the service was not noted and used to assist staff to understand them better. This meant staff were unaware of the importance of personal histories in delivering personalised care and the result of this was that care was tasks led and people personal needs and wishes were ignored.

Care plans contained very basic information. People who had highest needs did not have these needs explored and explained to staff. Therefore staff did not have directions on how to care for them effectively or how to respond to them. Staff were not able to recognise triggers to people's behaviours and by doing this be able to prevent harm to people and themselves.

People's whose behaviours challenge did not have these behaviours explained in their records. Staff were not given direction on how to mitigate these behaviours. This resulted in people's needs and wishes not been being recognised and met. None of the care plans contained personal information on people.

There was no personal history to assist staff to understand and make people's life easier and more enjoyable. This meant that care was based on physical needs only. One family member told us they had talked about their relatives care but had not seen their care plan. The lack of detail in care plans created a risk that of information passed on was inconsistent. This increased the risk of people receiving poor or inappropriate care.

The staff who cared for people had no way of ensuring their knowledge of people was captured and included in care planning or care giving. For example, one area of the service had very large black silhouettes on the wall of the lounge area. Some people who were living with dementia were frightened of these. Staff had repeatedly asked for them to be removed. The management team did not have them removed until we asked them to do so.

Most people were without stimulation. One person said, "There is not enough to do." A staff member said, "They [people] could do with more entertainment." There were no newspapers, magazines or objects of interest in the service. Some people bought their own papers but the provider did not take responsibility to

ensure people were stimulated. We saw people walk without purpose around parts of the service. Staff did not know enough about them to offer support or intervene in a positive manner.

We talked to staff about people's hobbies and interests. They were unable to tell us about these. Some staff had some idea about people's past. No staff we spoke with had clear and concise knowledge. We were told people like to sit in the lounge. We noted a television was on in the lounge area of the nursing area. Most people couldn't hear it and some people couldn't see it. We saw that they dozed on and off. The new manager was aware of the lack of stimulation and we discussed plans they had to increase stimulation for people particularly in the area of the service where people who were living with dementia.

People who lived in the residential area of the service were seen to have a little more stimulation and on the second day of our inspection visit they had a visiting musician to entertain them in the afternoon. People who were able to attend this were invited from all of the service.

We were told no-one had wanted to make an official complaint and therefore no complaints had been recorded since our last inspection. This meant there was no record of complaints or concerns or of any actions taken. There was no system to monitor what issues people raised and therefore the opportunity to learn from people's feedback was not taken in a systematic way.

Inadequate

Is the service well-led?

Our findings

In February 2016 we inspected Osmaston Grange Nursing Home and identified a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. The provider submitted an action plan and assured us the people who used the service would have an effective quality assurance process by the 31 August 2016. This had not been done.

We found there was a quality assurance process in place. However this was not fit for purpose and had not identified and addressed the issues raised on our inspection visits.

The provider's statement of purpose states "Osmaston Grange Care Home aims to provide person centred care by addressing its resident's physical, emotional and spiritual needs." Care plans did not explore what people emotional and spiritual needs were therefore the provider had no way of knowing or meeting those needs.

The provider did not protect people from risk. There was no effective ways of identifying and responding to risk. Therefore people and staff were not always kept safe from abuse and the risk of harm. We found 82 recorded incidents by staff. These included at least 77 incidents where staff were abused or injured. The assistant director and the acting managers of the service were not aware of these incidents and therefore had not put an effective risk reduction plan in place.

The provider did not have effective processes in place to ensure care plans and risk assessments were fit for purpose. Risk assessments were basic and they did not give staff guidance to how to recognise and respond to risk. Staff did not receive any direction on how to manager these behaviours or what to do when they or a person using the service had been assaulted.

The provider did not have effective process in place to recognise and address staffing needs. People were not having their needs recognised and met because staff levels were not sufficient to keep people safe. The impact of this had not been considered and was not addressed until we asked the provider to do this. We observed people left unattended throughout our inspection visits.

The provider did not have effective processes in place to manage staffing levels they considered necessary to meet people's needs. This included replacing staff who were ill or on holiday.

The provider did not have effective processes in place to ensure there was sufficient staff deployed appropriately to meet people's needs and wishes in a person centred manner. A review of care showed people were not offered the opportunity to pursue hobbies and interests. There was one activities person in place to offer stimulation over three sites. None of the people we spoke with or observed had the opportunity to pursue their hobbies or interests.

The provider did not have processes in place to recognise and address the rights of people under the Mental Capacity Act (MCA) and their rights under the Deprivation of Liberty (DoLS). None of the staff had an

understanding of people's rights under the MCA. This had not been recognised and addressed. Because of this people were being restricted without the correct legal process being followed.

The provider did not have effective processes in place to recognise and address the staff's training needs. The provider identified training they considered necessary for staff to care for people in a safe effective and responsive manner. This included effective safeguarding adults, moving and handling and health and safety. Records showed this was not achieved.

The provider did not have effective processes in place to alert the CQC and the Local Authority (LA) of incidents that may have a detrimental effect on people who used the service. This meant the CQC and the LA did not have the information they needed to assess the risk to people and take action as they saw appropriate.

The provider did not have processes in place to ensure issues raised in their questionnaire completed by people or relatives were addressed. This meant areas of the service people were not happy with, were not addressed.

The provider did not have processes in place to recognise and address the lack of involvement in care planning. None of the care plans we looked at had evidence to show people or their representatives were involved in developing care plans. Therefore the provider had no effective way of knowing if they were delivering the care people wanted or felt they needed.

The assistant director and the provider visited the service on a regular basis and had seen the areas we were concerned about. Yet their quality assurance process did not recognise these as areas of concern so no action had been taken. People were expected to live in unacceptable conditions. The provider had not taken effective action to ensure the service was developed and improved for the people using it.

The provider did not have effective processes in place to recognise and escalate safeguarding concerns and if appropriate for staff to use the whistleblowing procedure where people were at risk.

The provider had a whistleblowing policy and although most of the staff we spoke with had a basic understanding of what it involved they had not used it to highlight the risks to people using the service. When explored it was clear staff did not fully understand the policy and were not given updates on how and when to use it. Therefore risk to people and staff had gone unreported.

We found the staff to be demoralised and lacking in leadership and direction. Most of the staff we spoke with had the best interests of the people they cared for at heart. However they told us they felt they were not listened to. One staff member said, "It has been horrendous and certain people get away with things" Another said, "No one listens." A third said, "Some staff refuse to work on different units and they get away with it."

There were no systems in place to capture staff knowledge of people's needs and wishes and to use this knowledge to develop the service. Staff were not listened to and as a result of this the morale of staff was very low. The manager of the service were described as 'not supportive and not approachable. One staff member said, "I wanted to raise issues with the manager about people's care but there is not point. No one listens." Another said, "We try to do our best, but some staff do nothing and still get paid the same as us." Another said. "It's not nice to be here at the moment and the communication is terrible. It used to be so nice".

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff described the home as "friendly" and "a nice place to work" and the acting manager as approachable". All the staff we spoke with said they had confidence in the new acting manager, who had recently been appointed, to make the required improvements.

The provider is required to have a registered manager at Osmaston Grange. The manager of the service was not registered at the time of our inspection visit.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have process in place to promote people's rights under the Mental Capacity Act. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed to meet people's needs. Persons employed by the service did not always receive appropriate support, training, supervision and appraisal to enable them to carry out their duties they were employed to perform. Staff were not always recruited appropriately.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not ensure people were protected from the risk of infection because there were not thorough cleaning processes in place in the service.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have thorough processes in place to manage, review and action improvement needed to the service.

The enforcement action we took:

We issued a warning notice