Mr. Geoffrey Briddick

Ocean View Care Home

Inspection report

55 Ash Hill Road
Torquay
Devon
TQ1 3JD

Tel: 01803293392

Date of inspection visit:
23 April 2018
25 April 2018
30 April 2018

Date of publication:
08 May 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Ocean View Care Home (known as Ocean View) provides accommodation and personal care for a maximum of 25 people. People who live at Ocean View have dementia or mental health needs. Some people also have physical disabilities. The home does not provide nursing care. People who live at the home nursing and healthcare through the local community health teams. Accommodation is provided over two floors with a passenger lift providing access to the first floor. However, there are a number of rooms unsuitable for people with impaired mobility as they are accessed by stairs. At the time of the inspection, 17 people were living at the home.

Ocean View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had 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.

This inspection was unannounced and took place on 23, 25 and 30 April 2018.

The home had previously been inspected in November 2016 where it was rated Requires Improvement. At that time we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to how the home managed people's medicines, the safety the environment, the safety of the staff recruitment processes and how the home monitored the quality of the service provided to people.

Following the last inspection, we asked the provider to complete an action plan to tell us what they would do to improve the key questions of safe and well-led to good. The provider sent us an action plan in relation to the actions necessary to meet the fire safety requirements but not one for the other areas for improvement we identified.

At this inspection in April 2018, we found people could not be assured they would receive safe care and treatment. We identified a number of issues in relation to the quality and safety of the support provided. These included issues around medicines administration, mitigating risks, care planning, staff training, opportunities for engagement, as well as the management of the home. Further improvements were necessary to the environment in relation to cleanliness and its suitability for people living with dementia, as well as safety issues such as trip hazards and limited handwashing facilities.

Prior to this inspection the home had been placed into "whole home" safeguarding process by Torbay and South Devon NHS Trust (the Trust). This meant the Trust had received information that people were at risk

of harm and they were carrying out their own investigation and taking action to protect people where necessary.

Risks to people's health and safety were not being managed well. Risk assessments and care plans did not always provide staff with sufficient information to guide them in their actions to protect people. Where guidance was provided this was not always being followed. For example, people requiring assistance from staff to manage their pressure area care and continence needs were not receiving an appropriate level of support. We found one person had been experiences harm and we made a referral to the Trust's safeguarding team in relation to their care.

Some people's medicines were not managed safely. While most people received these safely, we observed some unsafe practice. One person was not offered their medicines in a way that meant they were less likely to refuse them and we found unused medicines stored in open and unnamed pots in the medicine trolley. This meant people were at risk of not receiving their medicines as prescribed.

Some people had a high risk of falls. These people did not have an assessment or a management plan in place to mitigate these risks. The home's accident records did not accurately reflect the number of falls one person had sustained. People's risk of falling was increased due to the poorly maintained carpets. The join in the carpet in the lounge room and in a person's bedroom, were coming apart causing a potential trip hazard.

The home was found to be unclean and, in places, offensive smelling. There were limited handwashing facilities in some bathroom and toilets. Some sinks did not have a hot water supply fitted and one where there was no sink, did not have hand-cleansing gel. The provider told us they had a refurbishment plan for the home. However, at the time of the inspection we found furniture and carpeting were unclean and some was in a poor state of repair.

The environment was not suited to the needs of people living with dementia. There was no signage around the home to help people orientate themselves and to find the toilets or the communal areas. There were no pictures on the walls and no items of interest for people to engage with or which could be used to stimulate conversation. People's bedroom doors were indistinguishable from each other. The locks used on people's bedrooms doors were not suitable for people with impaired dexterity or for those people who might not have the cognitive ability to open a lock and a door handle at the same time.

At the previous inspection in November 2016, we identified the home had failed to obtain disclosure and barring checks (police checks) for two members of staff. At this inspection, we found that although the home had undertaken the necessary pre-employment checks for a newly appointed member of staff, the home had failed to obtain a check for the staff identified at the previous inspection.

People were unable to tell us whether there were sufficient staff on duty to meet their needs. The registered manager and staff said there were sufficient staff available. However, during our observations, we saw staff only attend to people when providing them with support to eat and drink. Some people had not received support with their personal care. At times people were unsupervised in the communal areas, including those people who were at a high risk of falls.

Those people who were able to share their views with us said they felt safe at Ocean View. Staff had received training in safeguarding people from abuse as well as in the Mental Capacity Act 2005 (MCA). However, it was not clear that staff were always putting their learning into practice. Staff were not being supported to recognise the environment within which people were living was not respectful and did not meet people's

emotional and psychological needs. Staff spoke about people with affection and friendliness. However, people's dignity and privacy were not always respected by the staff, registered manager and provider. We observed people sitting in their underwear and other people in an unkempt state and we heard derogatory remarks made about people.

We also observed good practice from staff and saw them to be friendly and caring when engaging with people individually. It was clear staff knew people well when engaging with them in conversation. People were seen to enjoy staffs' company and those people who had limited verbal communication were seen to make eye contact with them and smile. Staff told us how much they enjoyed working at the home. One member of staff said they thought of the people living in the home as "family" and another said people were "loved" by the staff.

Staff told us they received regular supervision and had the training they needed. However, from our observations and from reviewing care records and those relate to staff training, we identified staff required further training to support people's physical and mental health needs. People's pressure area care, continence management, as well as their needs related to living with dementia and mental health conditions were not being appropriate or safely supported.

There were few opportunities for people to engage in leisure or social activities to provide stimulation and engagement. We observed people spending long periods of time without any staff involvement or engagement other than when they were being supported to eat and drink. When people were engaged in an activity or when receiving staff attention, it was clear they enjoyed this.

People told us they enjoyed the food provided by the home. People were offered a choice of meals and staff were aware of their preferences. Those people who required their food to be modified, such as pureed due to swallowing difficulties, received appropriate support. However, for those people at risk of malnutrition and dehydration, monitoring of their food and fluid intake was not effective in ensuring they received enough to eat and drink.

At the previous inspection in November 2016, we found the home's quality assurance and monitoring systems were not effective and had failed to identify the concerns identified at that inspection. At this inspection, in April 2018, we found improvement had not been made and the home did not have effective systems in place to assess, monitor and improve the quality of the service provided. The registered manager told us feedback from people was sought, but there was no record of this.

The provider and registered manager told us they were committed to making improvements and recognised the home had not been providing the level of care and support it should. A staff meeting had been arranged for the third day of the inspection to discuss the changes needed to improve people's experiences and to ensure they received the care and support they required.

We found shortfalls in the care and service provided to people. We identified 12 breaches in regulations. 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.

Following the inspection all the people living at the home were moved by the commissioning authorities to alternative care provision and the home remained unoccupied. We placed a condition on the provider's

registration preventing them from admitting any person to the home without the prior written agreement of the Care Quality Commission.

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.

Risks to people's health, safety and welfare were not always mitigated. One person had been exposed to harm.

Medicines were not always managed safely. People could not be assured they would receive their medicines as prescribed.

The provider had failed to obtain a disclosure and barring check for staff identified as requiring one at the previous inspection. This meant people could not be assured staff were suitable to work in a care environment.

People were exposed to risks from the poorly maintained environment and from limited handwashing facilities.

Staff support was not deployed in a flexible way that ensured people's needs could be met at their preferred time, or to ensure people received supervision to maintain their safety.

Staff understood how to report any concerns about people's welfare. People felt safe.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the training required to enable them to meet people's needs and keep them safe.

People were not always referred promptly to external healthcare services and their advice was not always followed.

People's rights under the Mental Capacity Act 2005 were being respected. The home had commenced capacity assessments and recorded best interest decisions.

People enjoyed the food. However, systems were not in place to ensure people received enough to eat and drink to maintain their health.

Is the service caring?

Inadequate

The service was not caring.

People told us the staff were friendly and caring and we saw this in some of our observations. However, people's privacy and dignity was not always respected.

People's independence was promoted. However, those people at risk of self-neglect were not supported in way that ensured their needs were met.

Staff enjoyed working at the home and spoke about people affectionately.

Is the service responsive?

Inadequate

The service was not responsive.

People could not be assured their care needs were fully understood and would be met. Care records were not always accurate and did not provide staff with the guidance they required to support people with complex care needs.

Activities were limited and there was little to interest or occupy people.

Complaints and the actions required to investigate and resolve these were not recorded.

Is the service well-led?

Inadequate

The service was not well-led

The provider had failed to provide an action plan to CQC after the previous inspection and had not notified CQC of significant events they are obliged by law to do so.

The provider had failed to display the home rating.

The provider did not have effective systems and processes in place to assess, monitor and improve the service or assess, monitor and mitigate risk.

The provider and registered manager confirmed their commitment to making the necessary improvements.

Ocean View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23, 25 and 30 April 2018. The first and third days of the inspection were unannounced. Two adult social care inspectors and an expert by experience with experience of services for older people living with dementia undertook the inspection on the first day. One adult social care inspector continued with the inspection of the second and third days. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and any statutory notifications we had received from the home. A notification is information about important events which the service is required to tell us about by law. Prior to this inspection the home had been placed into "whole home" safeguarding process by Torbay and South Devon NHS Foundation Trust (the Trust). This meant the Trust had received information that people were at risk of harm and they were carrying out their own investigation. They shared this information with us and the inspection gave consideration to these concerns.

During the inspection we spent time in the communal areas of the home to observe how staff supported and responded to people. The majority of people at Ocean View were living with dementia or had mental health needs. We spent time carrying out a short observational framework for inspection (SOFI) observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care. We spoke with the provider, registered manager, four care staff, nine people and three relatives.

We looked at a number of records relating to people's care and the running of the home. These included three people's care and support plans, two staff personal files and records relating to staff training, medication administration and the quality monitoring of the home.

Inadequate

Is the service safe?

Our findings

At the inspection in November 2016 we found people's medicines were not always managed safely, people were not protected from environmental risks and staff recruitment practices were not always safe. At this inspection we found some improvements had been made with the environmental risks, but the management of medicines and staff recruitment practices continued to require improvements to meet the regulations, and to ensure people received safe care and support. We also identified other risks to people's health, safety and welfare which were not being well managed. The actions taken by the home did not mitigate these risks. We made a referral to the Trust's safeguarding team in relation to one person's care.

The home had recorded a number of assessments for each person to identify risks to their health and safety in relation to their care needs. For example, some people had risks in relation to skin care and the development of pressure ulcers, nutrition, and mobility. However, we found that not all of these had been completed with sufficient detail to ensure risks were minimised. Where guidance was given, this was not ways being followed to ensure people were supported safely.

The assessment for one person at risk of developing pressure ulcers, (and who had recently had a pressure ulcer), identified they were to have their position changed every 1½ to 2 hours while they were in bed; and they should have their feet supported by a pillow to prevent pressure on their heels. The risk assessment did not refer to how often they should have their position changed when out of bed. Further information in this person's care records, dated 18 April 2018, relating to a community nurse's visit, stated this person had a pressure ulcer. They gave guidance to staff to support this person to return to bed during the day for periods of rest to prevent further skin breakdown. While we observed the person's feet were supported by a pillow, we saw, and records showed, this person was not always receiving the pressure area relief identified in their care plan or as advised by the community nurses. For example, over several nights the person did not have their position changed for periods of up to three hours. On 23 April 2018, the person had been out of bed for over 7½ hours. On 24 April 2018, they had been out of bed for 8hours. On these days they had not been supported to return to bed as recommended.

On 26 April 2018, a record made in the home's communication book, used to pass on important information between staff, stated this person's pressure ulcer had re-opened. There was no record of this in the person's care records and the staff told us they had not reported this to the community nurses. This meant the community nurses were not in a position to provide further guidance for the person to ensure they were receiving the correct level of support to promote healing and prevent further skin breakdown. We notified the Trust's safeguarding team about our concerns over this person's care.

On the first day of the inspection we observed some people receiving their medicines. While most people received these safely, we observed some unsafe practice. One person was authorised to have their medicines given to them covertly (without their knowledge). However, staff did not offer the medicines hidden in food and the person refused to take them. One of their tablets was dropped on the floor and the staff member picked it up and offered it to the person to take, rather than obtain another tablet. The member of staff did not return with the person's medicines disguised in food in an attempt to get the person

to take them.

We found three open and unnamed pots of medicines in the medicine trolley. The member of staff administering the medicines, and the registered manager, did not know why these medicines had been left in the trolley or how long they had been there. They did know why the medicines had not been disposed of. The member of staff had not been informed of anyone who had not taken their medicines. This demonstrated poor practice. Should a person refuse their medicines this should be documented, staff should be informed to enable them to seek guidance from a healthcare professional if necessary and the medicines disposed of.

The registered manager told us there were four people whose risk of falling was high. However, no risk assessments had been completed in relation to this. There was no management plan in place to reduce their risk of falling. For example, one person had fallen in November and December 2017 and in January 2018. There was no risk assessment in place and no record of these falls had been recorded in the home's accident records. The person's care plan identified they often moved furniture in their room, but we found this person's furniture had not been secured to prevent its movement and reduce risks to this person's safety. On the first day of the inspection, we observed this person walking while wearing only one slipper and no socks. Staff did not support the person to find their other slipper.

In addition, records showed this person had left the home on two occasions on 18 April 2018. Although this person had been safely returned to the home, there was no information about this in the person's risk assessments and staff were unable to identify how the person had left the home without them knowing. During the inspection a member of staff was heard to say about this person, "It's always worrying when [name] makes a dash for the door, not that I've ever seen him actually dash of course." The home was aware of the risks to this person from falls and from leaving the home but had not taken action to ensure the risks were minimised as far as possible.

People were being exposed to risk from the poorly maintained environment. The join in the carpet in the lounge room was coming apart causing a potential trip hazard. This was in the area leading to the smoking room and to the toilets, an area frequented by people throughout the day. We also saw the join between the bedroom flooring and the en-suite flooring in one person's bedroom had come apart and the flooring was lifting. This person mobilised without the support of staff and had been identified as being at a high risk of falls. This meant they were at an increased risk of falling when using their en-suite toilet.

Failure to manage people's medicines safely, to assess risks to people's safety and to do all that is reasonably practical to mitigate risks is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At the previous inspection in November 2016, we identified the home's recruitment practices were not always safe. The home had failed to obtain disclosure and barring checks (police checks) for two members of staff. At this inspection, we found that although the home had undertaken the necessary pre-employment checks for a newly appointed member of staff, the home had failed to obtain a check for the staff identified at the previous inspection. The registered manager said these staff were related to the provider and felt a check was not necessary. However, these staff had unsupervised access to people, and as such were required to have a disclosure and barring check to ensure their suitability to support people who may be vulnerable due to their circumstances.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Infection control practices were not always safe and the home was found to be unclean and in places, offensive smelling. Carpets in the communal areas and in some people's bedrooms were stained, and some furniture was in a poor state of repair. We saw one person's wheelchair to be unclean and other armchairs in the communal areas and in people's bedrooms were dirty with food debris under the seats. Two people's bedrooms had strong offensive odours.

Two hand-wash basins in communal toilets were not fitted with a hot water supply. One bathroom with a bath and toilet did not have a hand-wash sink and no hand-cleansing gel was available. One person's toilet did not have any toilet paper or towels for hand drying. This meant that people and staff were not able to wash their hands in warm water or to cleanse their hands after using the toilet or assisting a person to use the toilet.

Some people had needs in relation to continence management. To reduce the risk of cross infection, soiled laundry should be placed in a water-disposable bag. These bags were kept in the laundry room on the ground floor and were not available in people's bedrooms. Having these bags available where they would be needed would prevent staff having to leave people while assisting them to obtain one.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

During the inspection we saw staff using appropriate protective clothing to reduce the risk of cross infection, such as aprons and gloves, when assisting people with personal care or with eating.

People were unable to tell us whether they felt there were sufficient staff on duty to meet their needs. The registered manager and staff said there were sufficient staff available. However, during our observations, we saw staff only attend to people when providing them with support to eat and drink. At times people were unsupervised in the communal areas, including those people who were at a high risk of falls. Some people's personal care needs had not been attended to and some people were in soiled clothes. Staff were seen to be busy around the home attending to tasks such as laundry, rather than spending time with people. At the time of the inspection, in addition to the registered manager and deputy manager, there were three care staff on duty. Staff were supported by housekeeping staff and a cook. The registered manager confirmed these were the usual numbers of staff on duty. Overnight there were two waking staff members. We discussed staffing arrangement with the registered manager to identify whether staff had time to spend with people supporting them with their personal care. As some people were resistive to receiving support, staff would need to be flexible in their approach and repeatedly offer support which would be time consuming for them.

Failure to provide sufficient numbers of staff, and deploy staff in a way that ensures people's needs are met, is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Those people who were able to share their views with us said they felt safe at Ocean View; one person said they liked the home and another said it was nice. A relative told us they felt their relation was safe, saying, "Yes, and the carers are good."

Staff had received training in safeguarding people from abuse and demonstrated a good understanding of who they would report concerns to. The contact details of who to contact if they suspected someone was at risk of abuse, such as the Trust and the Care Quality Commission, were available in the office. Staff told us they felt comfortable and confident in raising concerns with the registered manager. However, from our observations we found that staff were not putting their learning into practice. They did not recognise the

environment within which people were living did not meet their emotional and psychological needs. People were placed in degrading situations and we observed staff disregard people's support needs.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The home supported a number of people with their finances. Individual records of money received on people's behalf and all expenditure were recorded. The provider said they bought cigarettes for people but did not charge them the full amount for these. They also said that when they take people out of the home, they charge £5 but people do not have to pay for any drinks or food. We checked the records and the balance of money held for five people and found these to be correct.

At the previous inspection in November 2016 we identified the home was not managing fire precautions safely. We made a referral to Devon and Somerset Fire Service who visited the home and required them to make improvements. Following their visit the provider confirmed to us that all the necessary improvements had been made and approved by the fire authority. At this inspection, in April 2018, records showed weekly checks of the fire alarm system were being undertaken and the fire alarm system had been serviced in March 2018. Each person had a personal emergency evacuation plan (PEEP) which provided information about the support people required in the event of an emergency. A summary of these needs was available for emergency services.

In November 2016, we also identified the home was not taking steps to minimise the risk of Legionnaires Disease. At this inspection we found that testing of the water temperatures was being made and water was being heated to the correct temperature to kill the legionella bacteria. Water temperatures were controlled in the sinks accessible to people to reduce their risk of scalds.

Inadequate

Is the service effective?

Our findings

Ocean View is registered with CQC to provide personal care and accommodation to older people who have mental health needs or who are living with dementia. However, people could not be assured they were receiving care and support from staff who had the skills and knowledge to support them in a way that met their needs.

Staff told us they felt they had the training they needed. One said, we have "lots of training" and another said, "I feel I know what to do." Staff told us they felt well supported by the registered manager and the provider. They also said they received regular supervision and attended periodic staff meetings to discuss work related issues.

The home's training matrix identified the training each staff member had received. Training had been provided in a number of health and safety topics, such as manual handling, food hygiene and first aid. However, staff had not received training in topics related to supporting people with mental health needs. Only the registered manager and one senior member of staff had received training in mental health care in November 2016 and May 2017 respectively.

Six out of the 17 staff recorded on the training matrix had received training in 2017 in dementia care. From reviewing people's care needs and from our observations during the inspection we found that staff were not exploring ways to support people who might be resistive to receiving assistance, or who might be difficult to engage with. Staff were not aware of how to provide care to people in a "dementia friendly" way. We saw people sitting for long periods of time, either sleeping or looking passively around. When asked what would make the home more suited to the needs of people living with dementia, staff were unable to make suggestions other than to have photographs of people on their bedroom doors. The registered manager told us they would be arranging training in dementia care but did not yet have a date for this.

Some people had needs in relation to pressure area care and continence management: two people had urinary catheters. The training matrix showed only three staff and the registered manager had received training in pressure area care in 2014 and one member of staff had received training in catheter care in 2016. Further training in catheter care had been arranged for October 2018. No staff had received training in continence care. People requiring assistance from staff to manage their pressure area care and continence needs were not receiving an appropriate level of support. We saw people who required their position to be changed to protect their skin and those who used continence aids did not received assistance from staff for long periods of time. For example, one person's care plan stated that, "During the day I am able to use the commode in my bedroom with the assistance of 2x carers." However, our observations and the person's care records showed this person did not receive any assistance with their continence care during the day on 25 and 26 April 2018.

The majority of staff, 11 of the 17 identified in the training matrix, had received training in diabetes management in 2017. Some staff had a good understanding of how to support people and what to be observant for should a person's blood sugar be too low or too high. However, we found some other staff did

not have a good understanding of the dietary restriction necessary to support people to maintain safe blood sugar levels. We heard one member of staff telling a person with diabetes that a dessert made with brown sugar was suitable for them to eat, despite the person questioning this. The relative of a person with diabetes told us their relation has at times, not been given breakfast.

Failure to provide appropriate training for staff to enable them to carry out their duties and to ensure they have the skills and knowledge to support people with complex care needs is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Records showed people were seen by healthcare professionals when the staff observed changes in their health and well-being, as well as for routine checks such as from an optician and a chiropodist. However, we found referrals to healthcare professionals were not always consistent which meant people were not always provided with appropriate support when necessary. For example, staff did not alert the community nurses about one person who had developed a pressure ulcer, despite them having visited the person three days prior to assess their skin condition.

Two people had epilepsy and their care plans instructed staff to monitor them for signs of seizure activity. One person was to have two hourly checks overnight. However, their care records did not identify whether these checks had taken place. Records for the other person showed they had been "twitching" but staff had failed to recognise this as possible seizure activity and did not report this to healthcare professionals. In addition health professionals expressed concern that their recommendations had not always been followed, which had put people at risk.

Prior to this inspection we were provided with information from the Trust's safeguarding team, that concerns had been rasied over people's nutritional needs and the home not seeking advice when people were losing weight. At this inspection, we found the needs of people at risk of malnutrition and dehydration were not being monitored to ensure they were receiving sufficient diet and fluids to maintain their health. Staff were aware of providing fortified foods to people and to increase people's fluid intake with soups, jellies and yoghurts, but were unaware of how much each person should be drinking each day. Records were not always fully completed and it was not possible to ascertain if people's intake was poor or if this was a recording error. There was no oversight by the registered manager, or an identified member of staff, to ensure people's food and fluid intake was adequate.

We observed one person being assisted to eat their lunch. Initially the member of staff supporting them engaged them in conversation and checked with them they were enjoying their meal. However, the member of staff left the person on three occasions without an explanation and the person had to wait several minutes until they returned. This person did not eat well at this time, although they did drink two drinks. Another person was given a nutritional supplement drink. When the person indicated they did not like the drink, the member of staff did not explain the importance of taking the drink nor did they offer the person a different flavour. They said they would bring the person a cup of tea, but after an hour they took the supplement drink away but did not give the person a cup a tea.

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

The environment was not suited to the needs of people living with dementia. The home had recently been redecorated but in pale colours and not in contrasting colours as is advised by dementia care specialist organisations. There was no signage around the home to help people orientate themselves and to find the toilets or the communal areas. There were no pictures on the walls and no items of interest for people to

engage with or which could be used to stimulate conversation. Outside space was only accessible through the smoking lounge adjacent to the main lounge room. Seating in the lounge room was institutional with chairs placed around the walls. This discouraged conversation and engagement. People's bedroom doors were indistinguishable from each other. The locks used on people's bedrooms doors were not suitable for people with impaired dexterity or for those people who might not have the cognitive ability to open a lock and a door handle at the same time.

In the home's service user guide, given to people when they moved into the home, the provider referred to meal times as an enjoyable social occasion. However, we found the dining room not to be conducive to supporting people's engagement with each other or an inviting place to encourage people to stay and eat. The room was spartanly decorated with two pictures on the walls and with the only furniture being dining room tables, placed against to the walls, and an empty dresser. Tables were not laid with tablecloths or condiments. During lunchtime music was played very loudly, enough to be heard in the lounge room next door over the sound of the television. This prevented people from engaging in conversation with each other. People were not given the opportunity to use the toilet before lunchtime or offered the opportunity to wash their hands. This meant that staff had not ensured people's comfort before they ate their meal.

Failure to take into account best practice guidelines in relation to providing an environment suited to people's needs is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People told us they enjoyed the meals provided by the home. One person said, "The food is fairly good, sometimes brilliant" and another person told us their lunchtime meal was "lovely." Staff knew people's food preferences and we saw people were provided with alternatives to the main meal in line with these preferences. One person indicated they were not enjoying their meal and staff asked if they would like a cheese sandwich. They said, "That'd be great" and staff brought them a plate of cheese sandwiches. Another person said they did not want anything to eat. Staff told us they often refused food, but if it was left with them, they would eat it; we saw this person ate all of their lunchtime meal.

Where people required their food texture to be modified, such as pureed for people with swallowing difficulties, their care plans described this and we saw them being supported in line with this 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. We checked whether the home was working within the principles of the MCA.

Staff had received training in the Mental Capacity Act in April 2018 and were aware of the need to gain people's consent when providing them with care and support. Records showed the home was in the process of completing capacity assessment following this training and the support they had received from the Trust. Although the registered manager acknowledged there were still some assessments to complete, people had their capacity to consent to receive care and support assessed. Where necessary best interests decisions had been made on their behalf, for example with continuing to take medicines. However, our observations identified that people's rights to receive respectful and dignified care and support were not being met.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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 registered manager told us nearly all of the people currently living in the home required some level of restriction to their liberty to keep them safe. For example, people were unsafe to leave the home unescorted and as a result to home had locks on all external doors. Applications had been made to the Trust to authorise these. However, due to the high level of applications received by the Trust only of these had been authorised. One person, who did not require the support of staff to go out from the home, told us they were free to come and go as they pleased and no restriction had been placed upon them.

In the home's service user guide the provider stated people should expect their life to be enhanced by the provision of their own "safe, well-maintained and comfortable private bedroom." People's bedrooms were personalised with photographs and people were able to bring items of furniture with them when they moved in. The registered manager said the home had a refurbishment plan but this was discussed verbally between themselves and the provider. There was no written plan or schedules of work but the provider told us that bedrooms were being redecorated and new flooring fitted. Some redecoration and repairs were still required both in the communal areas and in people's bedrooms. For example, some radiator covers were broken. Although these did not pose a risk to people as the covers were still in place, the lack of general maintenance did not give a good impression of the home. On the third day of the inspection, the provider and registered manager told us they would research best practice for dementia care and ensure changes would be made in line with these recommendations.

Inadequate

Is the service caring?

Our findings

In the home's Statement of Purpose, a document used by the home to describe services it provides, the provider stated people's rights were placed "at the forefront of our philosophy of care" and "Disabilities quickly undermine dignity, so we try to preserve respect for our Service Users' intrinsic value."

However, during this inspection we found people's dignity and privacy were not always respected. We observed people sitting in their underwear and other people in an unkempt state. One person's care plan stated, "I will sometimes just be wearing underpants, 1 x carer will have to encourage me to go into my room or the nearest bathroom to get washed and dressed but sometimes I will refuse, so to protect my dignity they will have to assist me to put some clothes on wherever I am." However, staff did not offer assistance to this person to dress until prompted to do so by the registered manager an hour after we arrived at the home. The person was keen to get dressed and smiled while they were being assisted. Another person was not assisted to put on their trousers until their relatives visited and asked a member of staff for support.

After the lunchtime meal we saw staff supporting people to return to the lounge room. People were seen to have food around their mouths and on their clothing. Staff did not assist them to return to their rooms to wash or change their clothes.

We observed staff opening people's bedroom doors without knocking and waiting for a reply before entering.

We also observed the registered manager not respecting people's dignity. They were seen to approach one person and hold their hands, saying they had a lovely smile and giving them a kiss on the cheek. However, they then said in front of other people, "I don't know what was on your hands but it's on mine now. I'll go and wash that off." They did not return to assist the person to wash their hands. They were also observed waking three people who were sleeping in their chairs, saying, "Guys, it's morning, look at you all asleep" but then made no effort to engage with them in conversation or to offer any opportunity to participate in any meaningful activity.

People's confidentiality was not protected. We heard the provider talking to one person about a health care issue in the lounge room in front of other people without guiding them to a more private area to hold the conversation. We also heard them talking to another person in the dining room, again in front of other people, about their financial situation. They also made derogatory comments about a person's past to us in front of them.

Staff promoted people's independence with their personal care. However, where people were physically able to take care of their needs but were at risk of self-neglect due to their mental health conditions, care plans did not guide staff about how to support people in a way that they would find acceptable. This meant staff had not explored different ways to support people, including involving others such as family, preferred carers or healthcare professionals and were accepting of people's situation without looking to improve their acceptance for support. As such some people were seen to have a neglected appearance.

Although care plans had been reviewed each month, there was no indication people had been consulted or their views sought about the care and support they received. The registered manager told us the home had a keyworker system, where a named member of staff was allocated to oversee a small number of people's care. They had the responsibility for ensuring people were involved in reviewing their care plans. However, the registered manager said conversations between people and their keyworker were not recorded.

Failure to protect people's dignity, privacy and confidentiality is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At times during our inspection, we observed staff to be friendly and caring when engaging with people individually. It was clear staff knew people well when engaging them in conversation. People were seen to enjoy staffs' company and those people who had limited verbal communication were seen to make eye contact with staff and smile. One person told us the staff "care for me" and another person said, "It's alright here I suppose." Relatives said they felt the staff were kind and caring. One relative said to us of one carer, "She's great though."

Staff told us how much they enjoyed working at the home. One member of staff said she thought of the people living in the home as "family". They said, "I think about people when I've gone home and plan what to do tomorrow." Other staff said that people were "loved".

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. At the time of the inspection, there was no one with a sensory impairment and information was provided to people verbally if necessary. Large print documents could be provided upon request.

Inadequate

Is the service responsive?

Our findings

Each person at the home had a care plan used to describe their care needs and to guide staff about how they should offer assistance and support. We looked at the care plans for three people. We found the plans either did not provide sufficient guidance for staff, or where they did, there was no record staff had followed this guidance.

Staff told us some people were resistive to receiving assistance with their personal care. We reviewed the care plan for one person who was seen to be in a state of undress and who had a strong body odour. Their care plan said they were independent with their personal care but that staff "will need to encourage me to wash and change my clothes. I will often refuse to allow staff to do this." The care plan also said the person was at risk of infection if not kept clean. There was no information to guide staff about how to support this person in a way they found acceptable. Staff reported this person would accept assistance from male staff, particularly at night, and had agreed to bath once a week prior to seeing the community nurse. Staff had not explored involving other male staff in the person's care to learn from the member of staff who was successful in supporting this person. The community nurse saw this person twice a week and the staff had not consulted with them to encourage this person to have a bath prior to each of their visits.

Another person's care plan described the guidance provided by the community mental health team. It said staff should allocate a period of time in the morning when the person would normally have personal care and ensure they used this time to engage with them therapeutically. This should be conducted at the same time every day so that the person became used to having their therapeutic contact consistently. This person's daily care notes did not reflect that this was happening. It was therefore not possible to ascertain whether this intervention was successful in encouraging this person to accept assistance with their personal care.

In addition, some people were known to become confused and agitated at times. For example, one person's care plan said they became agitated if they misunderstood staff or if staff misunderstood them. It said they can shout and swear and threaten staff by throwing things at them. The plan advised staff to be patient and to explain to the person their behaviour is "unacceptable" and if the person did not "calm down" they were to leave them. The person's care plan did not guide staff about how to support them at these times other than to give "reassurance" and to leave them alone. There was no information about how to approach this person in a way that would lessen their agitation or how long to leave them alone before trying to engage with them again.

Staff knew people well and were able to describe their care needs to us. However, for those people resistive to receiving support with their care needs, staff were resigned to, and accepting of, people's reluctance. This meant that some people remained at risk of neglect with their personal care.

There were few opportunities for people to engage in leisure or social activities to provide stimulation and engagement. People's daily care notes did not provide a description of how people had spent their time, with only care tasks recorded. It was therefore not possible to see if people had been offered opportunities

to become involved in activities. For example, one person's care plan described that they would "Love to have one to one time with the staff." However, their daily care records did not provide any information that this had occurred and we did not see staff spending time with this person.

We saw people were sat for long periods with very little stimulation. On the first day of the inspection, one person was sat in a chair when we arrived in the lounge at 8.50am and they remained in the same chair until shortly before we left at 4:45 pm. They were not offered any activity and had no stimulation apart from staff supporting them to eat and drink. Staff told us this person enjoyed listening to music. They said the person would laugh, smile and clap their hands. They said they enjoyed the weekly music activity from a visiting musician. However, this information was not recorded in the person's care records. Another person was asleep in their chair for over three hours before staff approached them to ask them to go to the dining room for lunch.

One person's relative told us the person spent most of their time alone in their room. This was confirmed by a member of staff who said, "It's good he's coming downstairs today, he's often just in his room." This person's care plan described their interests prior to coming to live at the home but did not provide any information about what activities they enjoyed since admission. During the inspection we saw this person receive a hand massage. They fully engaged with the therapist and was seen to enjoy their conversation. This was an activity that could be initiated by staff and used to engage with this person more often but there was no reference to this in their care plan. A small number of other people also enjoyed a hand or foot massage but other people were not offered the opportunity.

People were asked if they would like to play bingo and seven people living at the home said they would. Staff did not offer to support those people who required assistance to join in or provided them with other activities more suited to their needs. When the registered manager saw people playing, they said, "I've never seen so many of you play bingo."

Some people went out of the home to a local café with the provider three times a week. However, staff told us it was people who were more able and those people who required more support to engage in activities did not go. The home had a snooker table. However, this was fitted with a wooden top and not set up ready for people to initiate playing. People would need the support of staff to play. Other than the television, there was very little to interest or occupy people.

Failure to provide care to people that is appropriate to their needs and reflects their preferences, is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Those people who were able to share their experiences with us told us they had no complaints about the home. One person told us they wished to leave but this was not due to having concerns but from wishing to live more independently. The registered manager said the home had not received any complaints and the last recorded complaint in the home's records was in 2011. However, prior to the inspection, we were provided with information through the Trust's safeguarding process, which indicated a number of concerns had been raised but these had not been recorded through the home's complaints procedure. During the inspection a relative told us they had made complaints in the past but were not sure of the outcome.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staff spoke with fondness about people, and when they did interact with people, it was clear people enjoyed their company. Staff told us people would not be discriminated against regardless of their culture, religion

or sexuality. They said everyone would be treated equally. They were able to describe to us their understanding of one person's needs in relation to their religion.

The registered manager and one member of staff had received training in 2016 in caring for people at the end of their lives. The home was able to continue to care for people at this time with the support of the community nurses. The home had received several 'thank you' cards for relatives of people who had previously lived at Ocean View. The comments from one card received this year said, "A big thank you to all your staff for everything you have done for [name]. I can't praise you all enough."

Inadequate

Is the service well-led?

Our findings

At the previous inspection in November 2016, we found the home's quality assurance and monitoring systems were not effective and had failed to identify the concerns identified at the inspection. As a result of that inspection, we asked the provider to send us an action plan of the improvements they were going to make. However, with the exception of an action plan to address the fire safety issues, the provider did not send us a plan as requested.

At this inspection in April 2018, we found improvement had not been made and the home did not have effective systems in place to assess, monitor and improve the quality of the service provided.
The provider and registered manager had failed to address all of the issues identified at the previous inspection, including that of obtaining disclosure and barring checks for two members of staff who had unsupervised access to people. Whilst the environmental risks identified at the previous inspection had been resolved, other environmental risks were identified at this inspection.

People could not be assured they would receive safe, effective and responsive care that met their needs and protected their privacy, dignity and confidentiality. Staff had not been provided with, or had their understanding of people's care needs reviewed, to ensure they were skilled, knowledgeable and competent to provide care to people with complex physical and mental health needs. One person had come to harm as staff had not followed the guidance detailed in their care plan to reduce the risk of them developing a pressure ulcer.

The registered manager and provider failed to demonstrate their oversight of people's care needs and whether these were being met. Care records relating to managing risks to people's safety and welfare had not been monitored or audited to ensure people were receiving the care they required to reduce their risk of harm. People's care plans did not fully describe their needs and daily care records did not provide a comprehensive description of the care and support each person received.

The registered manager told us that, other than completing a monthly audit of the medicines held in the home, no audits or formal reviews of the quality of the service were undertaken. The provider visited the home three days a week and received a verbal report about people's welfare from the registered manager. However, no records were maintained of any action taken to ensure people's needs were met. The registered manager told us feedback from people was sought, but there was no record of this.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

During the course of the safeguarding process we were informed by the Trust that two people had died and some people had suffered an injury after a fall. Providers are obliged to notify CQC when this occurs and the provider had failed to do so.

This is a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

In addition, providers are required to display the home's rating following an inspection and, at this inspection in April 2018, we found the provider had failed to display the home's rating of 'Requires Improvement' from the November 2016 inspection. The registered manager told us this had been taken down during the redecoration of the home and had not been replaced. However, in a report given to the provider by the Trust in February 2018 informed them that rating needed to be displayed.

This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Although the provider told us they were committed to making changes, they had failed to provide an action plan to CQC as requested. Some of the failures had been bought to their attention during a previous inspection and through the recent safeguarding process. Some of the failings were not recognised by the registered manager or the provider as failings. For example, they failed to recognise people were not receiving care that was respectful, or that people were not being cared for in a way that protected their dignity. They did not recognise that the home was unsuited to the needs of people living with dementia and also smelt of offensive.

A staff meeting had been arranged for that afternoon to discuss the changes needed to improve people's experiences and to ensure they received the care and support they required. The registered manager told us they had a very good relationship with the provider and they were well supported. They felt confident the changes would take place. They described the provider as "excellent" and "brilliant". They said the provider would agree to purchase equipment necessary to meet people's needs. For example, new beds had recently been purchased following the advice from the Trust. One person told us they knew who the provider was saying, "He pops in quite a lot. He's nice, he jokes a lot."

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider failed to notify the Commission of the death of a service user.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents the provider failed to notify the Commission of a serous injury sustained by a service user.

The enforcement action we took:

We placed a condition on the provider's registration.

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 the care and treatment provided was appropriate to meet people's needs and reflect their preferences,

The enforcement action we took:

We placed a condition on the provider's registration.

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 protect people's dignity, privacy and confidentiality.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment The provider failed to ensure people's medicines were managed safely. The provider failed to assess risks to people's safety and to do all that is reasonably practical to mitigate those risks.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure the environment within which people were living met their emotional and psychological needs. The provider failed to ensure people were protected from degrading situations.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed ensure the environment was suited to people's needs. The provider failed to ensure the environment and equipment were clean and best practice in infection control measure were not being followed.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure complaints were recorded, acted upon and the outcome shared with the complainant.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure that all the necessary pre-employment checks for staff with unsupervised access to people had been undertaken.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider failed to display the service's rating.

The enforcement action we took:

We placed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of appropriately trained and competent staff were available to meet people's needs.

The enforcement action we took:

We placed a condition on the provider's registration.