Oaktree Care Ltd

College House Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: College House Residential Home is service that provides accommodation and personal care for up to 16 people. At the time of our inspection, 13 older people were living in the home, some of whom may have a physical disability and/or dementia.

College House is a 'care home'. People in care homes receive accommodation and 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 is in one adapted building over two floors.

There was a registered manager at the time of the inspection. However, during our inspection visits, we were told they were not available, and would be de-registering. A new manager was in post who told us they would be applying for registration, however five days after our inspection we were told they were not working at the service.

Rating at last inspection: At the last inspection the service was rated Good. The report was published 25 January 2017.

Why we inspected: This was a scheduled inspection based on the previous rating. However we had also received significant concerns from the Local Authority following their recent quality monitoring visit to the home so brought the inspection forward.

People's experience of using this service:

- People were not always protected from abuse because the provider's systems and processes to protect them were not in place to identify and respond to all allegations of abuse.
- People were exposed to significant risk of harm as their care needs had not been assessed, monitored and reviewed.
- There were enough staff on duty to keep people safe and meet their needs.
- People's medicines were not always managed in a safe way.
- Infection prevention and control practices were not monitored or reviewed.
- People were not supported to have maximum choice and control of their lives and staff did not work within the principles of the Mental Capacity Act (2005)
- Staff sought external healthcare professionals' advice but did not follow their guidance in how to support people.
- Staff spoke to people in a kind and caring way
- People's care was not delivered in a timely way, and changes in care were not always clearly communicated to the staff team.
- People were not supported to go on outings. People with dementia were not provided with activities that stimulated them.

● Record keeping of complaints was poor to enable the provider to demonstrate whether any had been received and acted upon in-line with their policy.
● The provider's quality assurance systems had not always been effective in identifying shortfalls in care and treatment for people. Improvements in quality assurance to assess, monitor, mitigate and improve the service were underway.

We found four breaches of regulation at this inspection: Regulation 11, 12, 17 and 18 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'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Follow up: We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not Safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not Effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always Caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always Responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always Well-Led. Details are in our Well-Led findings below.	**Inadequate**

College House Residential Home

Detailed findings

Background to this inspection

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Inspection team: One adult social care inspector and one expert-by-experience in older adults and dementia care undertook this inspection.

Due to technical problems on our part, the provider was not able to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

Service and service type: This is residential home. It provides accommodation and personal care for up to 16 people. It provides a service to older adults who may have physical disability and/or dementia.

Notice of inspection: This was an unannounced inspection.

What we did;
Before inspection:
● Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and local authorities.
During inspection:
● We spoke with seven people who used the service and five relatives. We spent time in the communal areas

to understand how people spent their day.
● We spoke with the four care staff, the cook, the manager and the area manager.
● We looked at aspects of three people's care records medicine records, nutritional information, incidents and accidents, residents and relatives meeting, staff meeting minutes and the complaints procedures.

After inspection:
● We spoke with the provider and the area manager.
● We spoke with the Local Authority and Safeguarding.
● We wrote to the provider for further information about the management arrangements for the service and an action plan to address the identified concerns..
● We spoke with the police following an incident at the service which was after our inspection visit.

Inadequate

Is the service safe?

Our findings

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

At our last inspection in January 2017, this key question was rated "Good". At this inspection we found the service had declined to Inadequate.

Inadequate: People were not safe and at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- Risks to people's safety were inadequately assessed, monitored and reviewed. We identified concerns with the management of choking, pressure area care and falls. Assessment of risk and plans of care where not in place to guide staff in how to mitigate risk of harm. Staff were inconsistent in how they supported people to stay safe.
- For example, one person was at high risk of choking and an assessment from an external healthcare professional identified they required a soft diet. However, there were no support plans in place to instruct staff how they should support the person to reduce the risk of choking. Staff gave varying accounts of how food and fluid should be given. Staff and the manager did not always recognise when they were putting the person at risk of harm and the Inspector had to intervene when unsafe food was being offered. We spoke with the area manager about our immediate concern of risk of choking. They put clear guidelines in place for the person and communicated this with staff and ensured they understood. We raised a safeguarding alert with the local authority following the incident we saw. On the second day of inspection we saw clear guidelines were in place and staff we spoke with understood the risk of choking for person we identified.
- Staff were inconsistent in their knowledge of who had pressure sores and how these were to be managed. Two people who had pressure sores and required bed rest did not have care plans or risk assessments in place to guide staff in how to support people to reduce the risk of deterioration and to promote healing. The care plan for one person did not indicate when they should have bed-rest, and while they were in bed how often they should be turned. Records we saw showed the person was sat in their chair for long periods of time, and when they were in bed there was no pattern or consistency with their positioning.
- The community nurse told us that their guidance was not always followed. For example, they had observed one person's pressure cushion was not being used consistently or their legs elevated as advised. A relative expressed their frustration with us about staff's inconsistency of this. We saw during the morning that the person did not have their legs elevated. The community nurses told us that staff over-inflated pressure cushions, causing damage to skin and this had been continually raised with management. The manager told us they were aware of this and had communicated with staff that they should not inflate the cushions.
- One person showed us a large bruise on their arm and told us they had fallen. Staff told us this person had fallen a few days ago. We saw the staff had reported three falls since January 2019, resulting in head injuries and skin tears, but no further care planning or risk assessments or consideration for further review could be evidenced. A visiting health care professional advised that they had not been made aware by staff that this person had had further falls since they last reviewed them for falls in December 2018. They advised that they would review this following our conversation.

Using medicines safely;
● The provider failed to ensure people were receiving their medicines as prescribed.
● Where staff had hand written medicine records for a person who required codeine, the frequency given did not match the prescription. We saw there had been two occasions when the medicine was given four hourly instead of six hourly putting the person at risk of harm. Following the inspection the area manager notified us and stated they had spoken with the person, their doctor and had raised a safeguarding.
● Where people were prescribed medicines as required, staff did not always have guidelines to follow as to when the medicines should be offered. We saw examples were as required medicines were given frequently without a rationale, staff we spoke with did not recognise this to be poor practice. A visiting healthcare professional advised they had seen a person heavily sedated, as the 'as required' medication had been given regularly instead of when the person was anxious and other techniques had not worked. They told us they had to amend the prescription to ensure staff did not over-sedate the person.
● We saw examples were people's regular medicines were given on an 'as required' basis, with no evidence of these being reviewed by the doctor to ensure this did not have a detrimental effect on the person.
● Stock control of medicine was not well managed. On inspection we found that one person's prescribed drinks thickener had run out that morning. Staff were waiting for the pharmacy delivery that evening, so the person could safely have a drink. The manager told us they knew the stocks ran out quickly but had not raised their concerns with the doctor or advanced nurse practitioner.
● Record keeping of medicines was poor. photographs used to identify people when administering medicines were sometimes missing and handwriting on some people's medicine records was illegible.
● We were not assured people were receiving their medicines as prescribed. We carried out sample medicines stock checks and found the actual and expected stock of medicines did not tally. The provider did not have an effective system of stock checks in place.
● Following our inspection the regional manager told us they had arranged for each person medicine to be reviewed with the advanced nurse practitioner.

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

Preventing and controlling infection;
● We found areas of the home did not promote infection control. For example, two communal toilets had been replaced, but the lino flooring had not been made good around the base of the toilet to ensure it could be kept clean. Carpets in bedrooms were visibly dirty with brown stains and some rooms had a strong smell of stale urine. In addition, armchairs were visibly stained and people's side tables were damaged and chipped.
● We saw the home's cat sat on the dining room tables, but the table cloths were not replaced before people ate their lunch.
● We saw staff used personal protective equipment where required.

Systems and processes to safeguard people from the risk of abuse;
● People told us they felt safe living in the home and staff demonstrated a good understanding of different types of abuse and what approach they would take in the event of any concerns.
● However, where staff and relatives reported safeguarding concerns to the registered manager, the provider's systems and processes had not been in place to ensure the safeguarding procedures were being adhered to. Further to this, when these safeguarding concerns were raised with CQC the provider followed their safeguarding procedures and reported these to the relevant authorities.

Staffing and recruitment;

● A high turnover of staff had affected staffing levels, which had meant that agency staff had been used. The manager reported that agency staff had been unreliable, and there had been a day when there were only two staff in the home to support 16 people. They told us they were recruiting more care staff and were not admitting any more people into the home until they had a stable staff team.
● The provider was recruiting senior care staff, a deputy manager and an activities co-ordinator into the home, as they recognised a wider skill mix of staff was required.
● Over the two days of our inspection we saw sufficient staff on duty to meet people's needs.
● People, relatives and staff felt there were enough staff to keep people safe and meet their needs. People reported that their call bells were answered promptly, and staff were available in communal areas.
● From the recruitment records we sampled, we saw that safe recruitment had taken place.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection Effective was rated "Good", at this inspection it had declined to "Inadequate".

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

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

- People were at risk of dehydration as staff did not consistently record how much fluid people who were at risk had drunk to ensure this was sufficient. We saw records which showed one person had not had sufficient fluids over a period of four days and their recorded output was low, but this had not been escalated. On the day of inspection at 14:30 we found that this person who required their drinks to be thickened had only received one cup of tea in the morning. Staff told us this was because the thickening powder had run out and they were waiting for the pharmacy delivery that evening. We escalated this to the manager, who was aware that the thickener ran out frequently and attempted to source more thickening powder but could not find any. The person had to wait for a drink until the pharmacy delivered that evening. While the person was given a special milkshake for their nutrition, the provider could not be assured that people had sufficient fluids to keep them healthy.
- People were not supported to have sufficient nutrition. Staff monitored people's weight. However, they did not take action when the records showed people had lost weight and required a review with the nurse or their doctor. For example, one person's care record showed they had lost 10kg in five months but had only received prescribed food supplement when a visiting healthcare professional observed how much weight the person had lost.
- People told us they enjoyed the food, but there was not much variety. People said they did not get a choice of main meal, and we saw people were given their food without being asked if they wanted what was given. People were not offered any more food once they had finished their meals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support;

- People's care needs had not been adequately assessed to ensure staff delivered care and support in line with their needs and associated risks had not been explored. For example, staff's knowledge of people's care needs varied and there was no clear guidance given to staff by way of care planning or communication between shifts.
- Staff did not consistently understand how to meet people's health needs in relation to risk of choking, management of pressure sores and risk of falls. Staff spoken with gave us different answers for management of care, and records we reviewed lacked detail to confirm what support people required.
- Community nurses reported to us that their guidance was not consistently followed by staff for pressure area care. Other areas such as people's continence needs had not been assessed. A staff member told us

that every person required continence pads, however the community nurse told us only five people had been assessed and prescribed these.
● Staff did not make appropriate referrals to healthcare professionals for the right care and treatment at the right time. A healthcare professional told us of an instance where they had noted a decline in a person's health and took action and made referrals as a result. Staff confirmed that this person's intervention had only started when the healthcare professional visited them and records we looked at confirmed this.

● Community nurses told us the communication between them and the staff was poor and said their advice was not consistently followed for pressure area care and were concerned about people's wellbeing. The area manager told us they would set up meetings with healthcare professionals to improve their working relationship.

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

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

● Staff had knowledge of the Mental Capacity Act principles but did not always apply these to their practice.
● Staff recognised they restricted people. While this was to keep them safe, the provider had deemed people lacked capacity without mental capacity assessments taking place to determine this. The provider had not ensured assessments had taken place, and where capacity was lacking best interest meetings had not been held which involved relatives, friends, advocates and healthcare professionals where important decisions were being made.
● The area manager told us that a manager from another service would begin mental capacity assessments and train senior care staff to complete these going forward.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Where staff had identified people were having their liberty deprived they believed that authorisations were in place.
● The provider could not evidence that authorisations were in place. The CQC had been notified of a deprivation of liberty in December 2017, however we had not received any notification of authorisations since this time. The area manager advised these would be completed in line with the MCA assessments.

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

Staff support: induction, training, skills and experience;
● People told us they felt confident with the staff who supported them.
● Three relatives did not feel confident staff supported their family members in the right way. For example,

one relative felt frustrated healthcare professional's advice was not followed consistently by staff.
● Staff told us they had done practical training such as first aid and manual handling. However, staff told us they had not kept up-to-date with other training, such as dysphagia (swallowing problems) training, mental capacity, nutrition and safeguarding.
● We saw staff did not always recognise poor practice, and the inspector had to intervene when unsafe food was going to be given to a person on a specialised diet. We reported this incident to the safeguarding authority as we could not be assured the person did not remain at future risk of harm.
● The area manager told us staff's training had lapsed and plans were in place to support staff to update their skills and knowledge. They told us they were supporting the home and we saw they led by example. The provider was aware that they could not evidence how they ensured staff were assessed for their competency in their skills and knowledge.

The above information is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs;
● The service had not been adapted to support people who lived with dementia.
● One person who required support with specialised cutlery did not have this.
● The furniture and decoration of the home was tired and in need of additional work to bring it to a good state.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection this key question was rated "Good". At this inspection we found how caring the service was towards people had declined and the rating was now "Requires Improvement".

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations had been met.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care;

- The environment of the home did not demonstrate that the provider was caring. We saw in some people's bedrooms that the carpets and beds had brown stains on them and there was a strong smell of stale urine in some of the bedrooms.
- We saw people's bedrooms were basic in their furnishings and the furniture within them old and worn. Ceilings had paint peeling off of them and walls had wallpaper peeling off of them.
- There was one toilet available to people downstairs and we often saw people queuing for the toilet and becoming a little distressed having to wait. The lift had been de-commissioned and the manager told us it could not be repaired due to its age. People shared with us their worries of using the stair lift. One person told us, "I need my walking aid here and I have to use the stair lift. I don't like it much, I feel vulnerable." Staff told us the stair lift took a lot of room, which made it difficult for them to get walking frames and wheelchairs up and down the stairs.
- Staff told us their frustrations with the environment and felt the home had been neglected, with the tired furniture, dated decoration and carpet. Staff felt the provider could do more to improve the home to make it a pleasant place for people to live. One staff member said, "It wouldn't take much to make it nicer, paint the walls, buy better furniture, better bath for people to use".
- We found there was an institutionalised culture within the home where people were not always offered choices, from their meals to what they would like to do with their day. For example, we saw people were not given a choice of meal, one person confirmed to us and said, "I don't get a choice of main meal but sometimes with sweet."
- A relative shared an example of an incident between their family member and a staff member and continued to say, "I tend to not ask the carers or senior carers about concerns, they can be funny. I worry my [person's name] could be ousted out."
- Staff felt limited in what individual support they could offer people. Some staff said that while there were enough staff to keep people safe and meet their basic needs, there were not enough staff to support people to go out to places they would like to visit. The manager had recognised this and had planned to employ an activities co-ordinator to support people with activities they enjoyed.
- People felt staff were kind towards them. We saw staff were kind towards people, listened to them and did not hurry them. Some staff engaged with people and spent time talking with them about their hobbies and interests.

Respecting and promoting people's privacy, dignity and independence;

● We saw staff treated people with respect by supporting them with their personal needs in a discreet and polite manner.

● Relatives told us their family members privacy was respected during personal care.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection, this key question was rated "Good". At this inspection we found the responsiveness of the service in meeting people's needs had declined and the rating was now "Requires Improvement".

Requires Improvement - People's social care needs were not always met. Regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control;
● Staff had limited guidance and directions in how to meet people's individual needs. Assessments of people's needs and preferences were not always in place to ensure a holistic approach was provided to people.
● Staff had used the assessment tools that were in place but did not implement the action required. For example, where one person was losing significant weight, staff followed guidance and monitored their food intake for three days. However, we found that over the three days, one day had no recording of meals, and the chart was discontinued after day three, even though the person was still not eating well. There was no evidence to support that the assessment tool was followed as it could not be evidenced that referral to a doctor or dietician had been made by the provider.
● Some people had high risks associated with fragile skin and required pressure relief. Although specialised mattresses and cushions were supplied, there was limited direction for staff regarding pressure relief in care plans. For example, one person who had a pressure sore, their care plan did not guide staff as to whether the person required bedrest, or how often they should be repositioned, therefore the person was not repositioned regularly or given routine bedrest. A healthcare professional told us they had advised staff not to alter the pressure within the cushions but found occasions when the pressure level within the cushions had been altered, which had caused further skin damage.
● Staff were not always kept up to date with people's changing needs. Staff reported that they only received information from the shift directly preceding theirs and missed information about incidents and accidents that may have happened, unless they searched through previous handovers.

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

● People were not always supported with activities that were stimulating or meeting their individual needs. Most people spent their time in armchairs with only the television as stimulation. One person told us, "There's not really any entertainment. Sometimes [manager's name] puts on something for us."
● Staff felt more could be done for people in terms of improving their social experience. A staff member told us they would be happy to volunteer their time to enable people to go out more, but this did not happen.
● The lack of appropriate activities had been identified as a concern by the manager, who told us they were employing an activities co-ordinator to improve the social aspect of people's support.

Improving care quality in response to complaints or concerns;

● The provider had a complaints procedure for people, relatives and staff to follow should they need to raise a complaint, however, people we spoke with could not recall having a copy of the complaints procedure.
● People told us they would approach management if they had any concerns. People felt comfortable to approach staff.
● There was not a clear recording system for complaints that had been received. Therefore, the provider could not be assured these were being addressed in line with their policy, or whether there were any patterns and trends that needed review.

End of life care and support;
● People's care files had some information about whether end of life care had been discussed and whether people wished to be resuscitated in the event of a medical emergency. The manager told us people could remain at College House for end of life care and would receive support from district nurses. There had been occasions in the past when people had remained at the service for end of life care; there was no-one currently in receipt of end of life care.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection, this key question was rated "Good". At this inspection the rating had declined to "Inadequate".

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Regulations were not met.

There was a registered manager who was registered in October 2010, however we were advised on inspection that the registered manager was not available and a new manager was in place.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on their duty of candour responsibility;

- There was inadequate management of the service to ensure the significant shortfalls we had identified were being addressed promptly and effectively. Five days after our inspection we were notified that the new manager was not working at the home. We wrote to the provider to understand how the service was being managed. The provider advised that the regional manager would be working in the home, along with support of a manager and deputy manager from another service. However, we were then notified that the regional manager was absent from work and the provider was out of the country, and the service was being supported by a deputy manager from another service.
- Staff had no records in place of how people's pressure sores were healing, the manager told us that these were only held on the community nurses' records. The manager told us that they did not always go with the community nurses to support people to be able to see and report how the sores were healing. Therefore, the provider could not be assured people's skin integrity was being maintained.
- There were no robust care plans in place to guide staff how to support people who required a soft diet. Staff told us they had not received the training required for supporting people who required alternative textured diets. We saw staff lacked knowledge in this area through practices that we saw. We raised this with the regional manager at the time of our inspection who confirmed that staff training was being reviewed and staff would be, "Starting [their training] from scratch."
- The provider did not maintain established systems and processes to ensure the service was consistently delivering safe and effective care. While the provider told us they were aware the care plans and risk assessments were lacking in detail the provider had failed to improve the risk assessments to people despite knowing there were shortfalls.
- The provider's systems failed to identify that when action was needed in relation to people's health care that this was not happening. We found that people experienced delays in the support they needed. For example, where two people were losing weight, evidence had been gathered by staff to determine they were not eating adequate amounts and continued to lose weight, but no there was follow through with this information to ensure the person's doctor had been notified so additional care could be provided.

● Accidents and incidents involving people were recorded. However, the provider and management team did not analyse these events to identify trends, and ensure action had been taken to keep people safe and reduce the risk of things happening again.
●The provider did not have systems in place to ensure the MCA was complied with and people were not unlawfully deprived of their liberty.
● The provider's systems had failed to ensure staff were suitably trained with the knowledge and the skills to support people with their needs. Staff told us they needed training in International Dysphagia Diet Standardisation Initiative (IDDSI) so they understood how to support people who required specialised diets safely.
● The provider failed to ensure people were supported in a person-centred way with access to the specialist care equipment they needed.
● The manager had put some measures in place, such as handover sheets to improve communication. However, this was not effective as staff told us communication was still poor and they did not always get up to date information. This included a lack of updates when people had suffered a fall or developed a pressure sore. From speaking with staff, we had inconsistent messages about how people were to be supported and the care plans we looked at did not clarify the care required.
● The manager had not prioritised their workload., Instead, they told us they were replacing toilets and arranging name labels for people's clothes. While we found there were other staff, such as a maintenance person who was employed to carry out some of these tasks. They told us they did not have a working computer or supernumerary time to complete care plans and effectively ensure their staff were delivering the right care and support in line with health care professional's guidance.
● The provider had support from a larger care company to support them with monitoring of the service. We saw that the area manager had completed a quality check in March 2019 following concerns identified by a visit from the local authority and had developed an action plan. The timescale to complete these actions had not been met and the provider could not demonstrate how they would rectify this.
● There was no clear processes or plans in place to manage the on-going maintenance and decoration of the home. We found the environment of the home to be in poor condition. There was a strong smell of stale urine in some bedrooms, brown stains on carpets and beds and the furniture in some of the bedrooms were old and tired. Where staff had been injured by the sash windows and one person living in the home had broken a window, it could not be evidenced that risks had been mitigated promptly to reduce risk of injury to people who lived in the home.
● The environmental health rating was not on public display as required. The manager explained they had been rated a 3 star in October 2018, but improvements to the kitchen had since been made, but a new rating had not yet been given.

The lack of robust quality assurance meant people were still at risk of receiving poor quality care and should a decline in standards occur, the provider's systems would potentially not pick up issues effectively.
This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The manager had held a resident and relatives meeting to discuss their views of the running of the service. The main concern was focused around mixed or missing laundry. The manager told us they were labelling clothes to reduce this from happening again.
● Staff had the opportunity of staff meetings and supervisions with the manager. Staff told us this was a positive experience, as they felt listened to, and were optimistic about the improvements that were being planned for the future of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the MCA were not followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing the provider had not ensured their staff had access to suitable training and were competent in their roles.