Health and Home (Essex) Limited

Ravensmere Rest Home

Inspection report

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Date of inspection visit:
04 October 2022
05 October 2022
11 October 2022

Date of publication:
21 April 2023

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

About the service
Ravensmere Rest Home is a residential care home providing personal care to 9 at the time of the inspection. The service can support up to 24 people living with dementia, mental health conditions and learning disability.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support:
The provider failed to have safe and robust systems in place when incidents and accidents occurred, and these were not reported which placed people at serious risk of harm.

Risk management was poor. Staff were not provided with enough clear guidance to support people safely.

There were limited opportunities for choice, control and independence. There was no activity schedule or plan and opportunities to access the community or to pursue individual interests or hobbies.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Where people lacked capacity to make decisions, the provider failed to put in place documents to support decision making.

Right Care:
Care was not always person-centred or designed to promote people's dignity, privacy and human rights.

Staff did not always understand how to protect people from poor care and abuse. The provider often delayed or cancelled visits from other agencies.

Not all staff were appropriately skilled to meet people's needs and keep them safe.

Right Culture:
People were supported by staff who did not understand best practice in relation to people with a learning disability and/or autistic people.

There were indicators of a closed culture. Staff did not ensure risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity. The routines within the service were not always personalised to individual people.

The provider failed to develop effective governance and quality assurance system to assess the quality and safety of the support people received. The provider failed to acknowledge the concerns consistently identified during inspections which meant improvements were not made to improve the care people received.

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

Rating at last inspection and update the last rating for this service was inadequate (published 23 December 2021). At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider reviews best practice guidance on creating a supportive environment for people living with dementia. At this inspection we found the provider had not acted on this recommendation or made any improvements.

Why we inspected
The inspection was prompted in part due to a safeguarding and continued concerns received about people living at Ravensmere Rest Home not having access to professionals and stakeholders involved in their care. The provider was continuing to not allow professionals and stakeholders to access the service to carry out their statutory obligations to ensure people's safety and wellbeing. A decision was made for us to inspect and examine those risks.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding, mental capacity, staff training and person-centred care.

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

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

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

This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

details are in our well led findings below.

Ravensmere Rest Home

Detailed findings

Background to this inspection

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

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

Inspection team
Two inspectors carried out this inspection.

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

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

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

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people and 1 relative, and we observed how people were being supported. We spoke with 3 members of staff including the provider who is also the registered manager. We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 3 staff files in relation to safe recruitment and a variety of records relating to the management of the service, including safeguarding incident records.

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 we rated this key inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection in August 2019, April 2021, August 2021 and October 2021 the provider failed to follow safeguarding procedures. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection, not enough improvement had been made and the provider was still in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• The provider had consistently failed to protect people from abuse or potential abuse.
• At previous inspections we identified incidents which could be abuse had not been referred to safeguarding authorities appropriately. At this inspection we continued to find not all accidents or incidents were being referred.
• A person had been found out in the community in a vulnerable position on 4 occasions. On the last 2 occasions they had sustained injuries that required treatment. These incidents had not been reported and the escalating nature of the incidents had meant the person was putting themselves at serious risk of harm.
• Another person had been punched by a person and sustained an injury to their face. Again, the provider failed to report this to the safeguarding authority and no additional controls had been put in place to protect this person or others from further incidents. This left people at risk of physical abuse. When we fed back this concern to the provider, they demanded the 2 people involved were brought into the feedback meeting to answer questions about the incident. We informed the provider this would be completely inappropriate.
• A person consistently repeated in communal areas they were unhappy living at the service, which staff that heard this ignored or did not respond to. When we looked at their Deprivation of Liberty authorisation (DoLS) a condition was in place which clearly stated that any objections the person made to living at the service should be recorded and shared with relevant parties. When we asked a senior member of staff about this, they were not aware of this condition. This meant this person's objections were not being captured or recorded.
• Concerns continue to be raised to CQC that the provider was delaying access by the local authority to investigate any safeguarding concerns.
• All above safeguarding concerns were subsequently referred by CQC to the safeguarding authorities following the inspection.

The provider failed to ensure that people were protected from abuse and improper treatment. This was the fifth continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last inspection in October 2021 systems were either not in place or robust enough to demonstrate

risks to people were managed safely. This placed people at risk of harm. At this inspection, not enough improvement had been made and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management
• People were at significant risk of harm as staff were not recognising potential risks and care plans were not updated. Concerns were found in multiple areas of people's support including fire safety, pressure care, risk of falling and distressed behaviours.
• We observed a person had access to cigarettes and a lighter in their room and the room smelt of smoke. Their risk assessment, care plan and information on their DoLS authorisation recorded they smoked outside, and staff should hold their cigarettes and lighter. When we spoke with a senior staff member, they confirmed this person was now smoking in their room and had access to cigarettes and lighters. The risk assessment had not been updated or any additional controls put in place to reflect this. CQC subsequently raised this as a safeguarding alert and informed the fire service..
• We wrote to the provider to request additional documentation in relation to fire safety to ensure people, staff and visitors were protected from a fire occurring and this information was not received. CQC took further action to ensure people, staff and visitors were protected from risk of harm.
• Personal Emergency Evacuation Plans (PEEPs) did not always consider people's individual circumstances that may impact on their ability to evacuate safely in the event of a fire. For example, one person consistently consumed alcohol which meant their mobility was affected when this occurred, and another person's medicines could lead to them becoming drowsy and potentially affect their mobility.
• There was a lack of oversight to identify and manage risks associated with the spread and control of infection, such as legionella, which placed people at risk of harm. Legionnaires' disease is a potentially fatal type of pneumonia, contracted by inhaling airborne water droplets containing viable Legionella bacteria. Water testing was not being completed for 11 vacant bedrooms which were left unlocked. This also meant people who moved around the service independently could be at risk of scalding if water temperatures were not within recommended levels.
• The fire risk assessment had not been reviewed since August 2021.
• One person had developed a pressure ulcer. When we looked at the person's skin integrity assessment (Waterlow) this had been reviewed after the pressure ulcer was noticed. The assessment score remained the same and the person's skin integrity care plan had not been updated to reflect they now had a pressure ulcer. In a care note entry, it was recorded this person should be repositioned every 2 hours. When we reviewed these records, repositioning was being completed every 4 hours.
• One person had been identified as high risk of falling and had an alert mat by their bed which alerted staff if they fell or got out of bed unsupported. In this person's room we noted the bed was placed on hard tiled flooring with laminated wood flooring in other areas of the room. This meant the potential for injury should this person fall was greater if they were to fall on the tiled flooring.
• Care plans did not always give information about people's health care needs. For example, one person had epilepsy and there was no guidance in place for staff to follow should this person have a seizure.

Preventing and controlling infection
• Systems in place to prevent and control infection were not always effective.
• Toilet brushes in people's bathrooms were heavily soiled.
• Hand soap and paper towels were not always available as some dispensers were empty.
• One shared bathroom's flooring was not sealed which meant dirt and grime had accumulated. Another shared bathroom had cracked tiles on the side of the bath which again could harbour germs or cause injury.
• PPE was not stored correctly, and boxes of gloves were in bathrooms and we found two boxes were torn exposing them to contaminants.

Using medicines safely

• Medicines were not always managed safely. Two people who lacked capacity were having their medicines administered crushed and disguised in food or drink. There was no pharmacy guidance in place to confirm these medicines were safe to crush or disguise in food or drink.
• PRN or 'as required' protocols did not contain sufficient guidance for staff to administer these medicines safely. For example, one person was regularly administered a drug as a result of distressed reactions. There was no guidance for staff about when to administer this drug or what therapeutic methods could be tried prior to administration.
• One person was receiving a medicine which is usually given for specific allergies or hay fever. When we asked a senior staff member what the person was allergic to or why they were taking this medicine they did not know.
• Medicine audits were not effective and just consisted of a tick sheet.

The provider failed to ensure the risks to people's safety were identified and acted upon was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• There was enough staff to meet people's basic needs. However, staffing levels were not sufficient to support people to go out or provide support for people to follow their interests or hobbies.
• Care staff had additional domestic tasks they were expected to complete such as, laundry and cleaning. This impacted on staff's availability to provide any sustained interaction or emotional support to people.
• Recruitment checks were undertaken prior to staff starting work. These included references and Disclosure and Barring Service (DBS) police checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Visiting in care homes
• People's relatives and friends were able to visit at any time in line with government guidance.
• Visits from representatives from the local authority or safeguarding authority were not always facilitated and the local authority told us visits were often cancelled or delayed.

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 our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At the previous inspection in October 2021 care was not always delivered with peoples consent and in their best interests. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the provider was still in breach of regulation 11.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• Consent to care was not always sought in line with guidance.
• People's care plans did record their ability to consent to their care and support. However, when people were unable to consent, mental capacity assessments had not always been carried out, or were out of date and best interest decisions had not been documented.
• A person who had an authorisation to deprive them of their liberty was asked by the provider to pay for the cost of DBS clearances for volunteers to support them to access the community. The person's deputyship had already informed the service this would not be appropriate, but the person was paying these costs. A safeguarding had been raised by a person's paid representative (A paid representative visits a person deprived of their liberty regularly to help the person to understand their DoLS authorisation and how it affects them. And, as far as possible, assist the person to exercise their rights if they want to). There was no mental capacity assessment or best interest meeting held prior to this decision. Whilst the safeguarding

alert recorded that the person had been repaid this cost their financial record did not show this refund.
• As recorded in the safe section of this report staff were not aware or following a condition on another person's DoLS.
• Three service users had an alert mat in place where an alarm sounded if they were to fall from bed or attempt to mobilise unsupported. Whilst a risk assessment had been carried out there were no mental capacity assessments or best interest meetings recorded or evidence the person or their representatives had been consulted prior to putting these alert mats in place.
• A person had recorded on their oral hygiene plan that their teeth were 'rotten black stumps' and they had refused to see or visit a dentist. There was no mental capacity assessment or best interest meeting to ensure this decision was in the person's best interest. The language used to describe the condition of this person's teeth was undignified, not person centred or following recognised guidance.
• Consent information in place for people remained poor, most people's consent information contained typed signatures of staff only and others had typed signatures of people some of which lacked capacity to understand this consent form. The consent form did not demonstrate that people or their representatives had been included or consulted appropriately about the statements included.
• Care plans did not always accurately reflect the person or their support needs. Care plans did not reflect when decisions needed to be made in someone's best interest.

Care was not delivered with peoples consent and in their best interests. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• The provider had not ensured staff had completed all relevant training.
• Staff had completed most training online. However, some staff had not received all the required training to support people effectively and maintain their safely. When we reviewed staff training, we identified that staff had not completed practical manual handling training. When we asked a senior staff member how staff were trained to use equipment such as hoists, they told us they showed staff. However, the senior member of staff was not qualified or trained to teach staff. This lack of practical manual handling training meant we were not assured that staff were able to move people safely.
• Senior staff had also only received first aid training online which would not be sufficient to respond to an emergency and provide the necessary first aid treatment.
• One person had epilepsy; staff had not received any training in relation to this health condition.

The provider failed to ensure some staff had appropriate training as was necessary to enable them to carry out their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us they received regular supervision and records confirmed this, however these records were repetitive and only recorded different training subjects. It did not record any information related to staff training needs, monitoring of their performance or their wellbeing. Records seen did not evidence a two-way meeting or record any information from individual staff members.

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

At our last inspection we recommended the provider reviews best practice guidance on creating a supportive environment for people living with dementia. The provider had not made any improvements.
• Signage remained limited and we could see no evidence that any work had been completed to create a more enabling environment for people living with dementia. There was a still lack of visual clues or items of interest around the service that could support wayfinding such as pictures, or objects of interest.

• Some people's bedrooms were quite bare and contained minimal personal items.
• We found one person did not have a shade covering the light bulb in their room and a side light did not have a bulb.
• Another person had a clock on their wall which had stopped and was showing the incorrect time.
• One shared bathroom had broken blinds at the window.

Supporting people to eat and drink enough to maintain a balanced diet
• People's individual food choices were not always catered for. Meals were plated and served. Whilst staff told us they had asked people earlier about their menu choices not everyone we spoke with confirmed this. One person told us, "You only get what you are given here there is no menu, no one comes around with a menu card. It is barbaric as there is no choice at all." Another person told us, "No, they usually give us nice food anyway. Nice meaty meals. We like it."
• There was no menu displayed in communal areas for people to refer to and the menu displayed in the kitchen which was locked was limited in the choices available.
• One person asked what was for lunch and the chef replied, "It is lamb chops and as I know you do not like lamb chops, I have done you a Cornish pasty." This did not evidence that the person was given the opportunity to choose an alternative meal choice.
• One person asked if they would have gravy on their food, the chef replied, "Of course you will have gravy on it, everyone will have gravy on it."
• People were also given drinks during the inspection; no choice was offered. Two people came to the kitchen door to request a hot drink. Whilst the Chef did provide this there was no conversation about whether the person could be supported to make their own hot drinks rather than having to knock on the kitchen door or ask staff for hot drinks.

All the above concerns demonstrated the provider failed to provide person-centred care and treatment that is appropriate, meets people's needs and reflects their personal preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People had access to healthcare professionals such as GP's, and district nurses.
• The provider had not worked with other agencies in an effective and timely way which we have detailed in the well led findings below.

Inadequate

Is the service caring?

Our findings

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

At the last inspection where we looked at the caring key question, we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not always treated well or with respect and dignity. The language used was not person centred and on one occasion within the hearing of the person, a staff member said to another member of staff they 'may become aggressive'. Using words or phrases that label, belittle or depersonalise people can have a big impact on them. It can change the way people feel about themselves, shaping their mood and self-esteem.
- In another interaction with inspectors a staff member discussed a recent incident about a person in a communal area and we had to ask them to stop as the person and other people were able to hear.
- Interactions between staff and people were task focused and limited during all 3 days of our visit. This meant the majority of staff interactions with people using the service was in relation to people's care needs, with minimal interaction with them at other times.
- Whilst there were records of resident meetings, there was no action plan to show how suggestions or comments people had made had been acted upon or put into place following meetings.
- Staff did not always sit with people to assist them when eating or drinking but stood and leant over them to support them to drink.
- People were not consistently involved in making decisions about their care.

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

- People's independence had not always been promoted by staff. Two people regularly knocked on the locked kitchen door to ask for a drink but were given no opportunity to either do this independently or with support. In a staff meeting in September 2022 this was recorded, "Help the individual to make a cup of tea, not to give ready. We can hold the kettle if their hand is shaking and help them to add sugar or milk to their tea." We did not see any evidence of this.
- During the inspection we found everyone's bedroom doors were unlocked. When we asked a member of staff if people were able to lock their door if they chose and if it was safe for them to do so, the staff member told us the doors were not able to be locked. This meant there was no opportunity for people to lock their bedroom doors should they wish for privacy or to protect their belongings. A person told us, "I have had 10 pairs of underwear and a leather jacket stolen from my room."
- A person lived with a learning disability; the provider had to ask staff who this person was when we asked about them. This demonstrated the provider, who was also the registered manager did not know the needs of the people at the service.
- Care was not always person-centred and did not always promote people's dignity, privacy and human

rights.

The provider failed to provide person-centred care and treatment that is appropriate, meets people's needs and reflects their personal preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• A visitor we spoke with was positive about the care the person they were visiting received. They said, "I think they are lovely; the staff are very nice. Whatever I ask them to do they do."
• Whilst interactions from staff were task focused some staff interactions were positive when they were supporting people.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection where we looked at the responsive key question, we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- There was not always sufficient and up to date guidance in the care plans or risk assessments around the specific needs of people. The plans did not provide staff with enough information so they could respond positively and provide the person with the support they needed in the way they preferred. For example, a person with epilepsy did not have sufficient guidance for staff about how to support them to ensure their safety.
- There were care plans that lacked information and details regarding people's life histories, important people in their lives, personal preferences and emotional and social needs. Care plans had not always been reviewed effectively to make sure they were comprehensive, accurate or up to date. For example, none of the care plans were reviewed effectively following incidents or accidents at the service.
- The language in care plans was not person centred. A care plan recorded a person would tease staff by refusing to put their clothes back on. Another care plan recorded a person may 'start acting out' if they are not given what they want. There was no consideration about what people might be trying to communicate to staff by their actions and why.
- There was no evidence people's relatives or representatives were part of the review process.
- People had limited information in end of life care plans. There was a lack of information and planning around any emotional and spiritual support needs and preferences as they were approaching the end of their life.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was a lack of social engagement at the service. During the inspection staff completed some limited activities with people but most people had little or nothing to do throughout our inspection except watch television.
- A senior staff member told us, "There is not an activity plan or programme. We do celebrate birthdays and prepare for parties." We observed people spent a lot of time without any social engagement from staff in communal areas. There was limited individual time give to people.
- There was limited opportunity for people to access the community and be involved in community events. A person told us, "There is nothing to do here accept watch TV. I have not been out since I have been here."
- At one point in the communal lounge the television was set to a music channel. Rap music was playing which contained lyrics that could be offensive to people listening.

The provider failed to provide person-centred care and treatment that is appropriate, meets people's needs

and reflects their personal preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says people should get the support they need in relation to communication.
• People's communication needs had been assessed and recorded as part of their care plan.
• People did not always have access to information in a way they could understand. The lunch menu not accessible or provided in a way that met their Individual needs and no visual choices were offered to people at the time of the meal.

Improving care quality in response to complaints or concerns
• We reviewed the complaints folder and noted there had been no recently recorded complaints. However, one person made complaints about the service very vocally and in communal areas where staff could hear throughout our inspection and none of these complaints were recorded or responded to by staff.

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 we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection there was a lack of governance and oversight. This resulted in a breach of Regulation 17 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The provider is also the registered manager of the service and did not ensure the service was well-managed and well led.
• The provider remains in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This is the seventh consecutive inspection where the provider has remained in breach of this regulation.
• This will be the fifth consecutive breach of regulation 13 safeguarding service users from abuse and improper treatment. The provider continued to fail to refer accidents and incident to the appropriate safeguarding authorities.
• Since December 2018, we have only rated this service as 'inadequate' or one that 'requires improvement.' The service has a history of breaching regulations and failing to sustain improvement. This showed a systematic failure in the provider's organisation and leadership of the service.
• Effective auditing arrangements were not in place. Where audits were completed these provided limited information or were not available. When we asked the provider if they completed any audits, they told us they would send them, but these have never been received.
• The provider did not demonstrate a willingness or commitment to work in partnership with stakeholders and other partner agencies, including CQC. There was poor collaboration and cooperation with external stakeholders and other services including CQC to achieve compliance with regulatory requirements. This indicated a 'closed culture'. The provider maintained their systems and arrangements were effective and they were not open to external professionals providing guidance or support to improve the service.
• Quality assurance and governance arrangements continued to not be reliable or effective in identifying shortfalls in the service. Specific information relating to this is recorded throughout this report and demonstrated the provider's arrangements for identifying and managing shortfalls and areas for development were not robust. There was a lack of understanding of the risks and issues and the potential impact this had on people using the service.
• The continued lack of effective oversight and governance of the service has resulted in continued breaches of regulatory requirements relating to consent, risk management including serious risk of fire, safeguarding

and governance. Additional regulatory breaches of regulation have also been found relating to person-centred care and staff training during this inspection.
• The findings throughout this report indicated a 'closed culture' as the provider was not effective in creating a culture of care in which staff valued and promoted people's individuality, protected their rights and enabled them to develop and flourish.

The provider had consistently failed to have effective oversight of the quality of care, risk and governance. This placed people at serious risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Following day 1 and 2 of the inspection the provider was offered the opportunity to record the feedback meeting on day 3 with both the provider and CQC having a copy of the recording, which the provider declined. Following the inspection, the provider told us they had made a recording on their phone of the feedback meeting without informing us or asking for our consent. This demonstrated the provider's lack of transparency and openness during the inspection.
• The provider had failed to identify or notify the relevant professional bodies as required which placed people at risk of serious harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The provider's relationships with some outside agencies had broken down. Due to a lack of leadership, closed culture and minimal reporting of incidents, we could not be assured people received the required support from relevant professionals as and when needed.
• People were not always supported to express their views and make choices and people's relatives or representatives were not always involved.
• During the feedback for the inspection the provider often responded angrily and defensively without considering the facts and issues raised. Throughout this feedback meeting the provider raised their voice, shouted and constantly interrupted us and asked inspectors to name and bring people into the meeting who had raised concerns.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide person-centred care and treatment that is appropriate, meets people's needs and reflects their personal preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not delivered with peoples consent and in their best interests. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the risks to people's safety were identified and acted upon was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of conditions

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 that people were protected from abuse and improper treatment. This was the fifth continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

Urgent variation of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had consistently failed to have effective oversight of the quality of care, risk and governance. This placed people at serious risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure some staff had appropriate training as was necessary to enable them to carry out their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent variation of conditions