# Oakdale Care Homes No. 1 Limited

# Kingfisher Court

## 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? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Kingfisher Court is a care home, based in Sutton in Ashfield (Nottinghamshire). The service provides personal care for up to 66 people. There are three floors at the service. The ground floor is called 'Acorn', the middle floor is called 'Birch' and the top floor is called 'Cedar'.

People's experience of using this service and what we found:
We observed that people received unsafe and neglectful care. There was no longer an open and transparent culture of reporting concerns and instilling change at the service.

There was a lack of guidance for staff to support people. Professional advice was not always recorded. Where guidance was provided, staff did not follow this which put people at high risk of harm. There was a culture of staff not updating records, having a poor handover of information and not reading records to understand people's changing needs.

There were insufficient staffing levels at the service. This resulted in unsafe and undignified care – particularly at night. Staff and relatives had raised concerns about low staffing levels for six months, but change had not occurred.

The service was unclean. Despite our inspection findings, an NHS audit identified ongoing cleanliness concerns a month later. There has been a failure to ensure the service is clean and people are protected from ill health.

There has been a lack of learning from incidents occurring at the service. Actions have not been taken to prevent re-occurrence and concerns raised by staff, people and relatives have not been resolved.

People were not supported to consume adequate drinks. This put them at risk of dehydration. People's specific textured diets were not documented or followed, this put people at risk of choking.

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

Staff told us that they had an inadequate induction to the service. Records showed us that training was not always up to date to ensure staff were skilled. Staff lacked knowledge on people's complex health conditions.

People's experiences were no longer at the forefront of the service. Low staffing levels, and poor staff attitude resulted in people being left unclean and in an undignified state. The outstanding caring attitude was no longer present, and people were no longer treated with dignity and respect.

Complaints were not responded to effectively, to ensure that improvements were made. People, staff and relatives had already raised many of the concerns that we identified. However, action had not been taken to improve the service.

There was a lack of personalised care at the service. People's preferences were not always recorded and people reported staff knowing them less well now. Staff advised that they try to follow people's routines however the ethos of the service was changing to fit people's routines in with general routines at the service rather than individual preferences.

People reported a lack of activities at the service since January. We observed minimal activities and stimulation on our visit. Efforts been made to recruit additional activities focused staff, the provider advised that care staff were expected to support activities where possible.

The service was no longer well led. There was a poor relationship reported between the staff and the registered manager. Staff had advised that they had reported concerns to the registered manager and provider, however felt a lack of action had been taken to improve the service. People told us and records showed us that the service was no longer working to its previously excellent standard. The provider had failed to recognise this and instil actions in a timely way. This left people at prolonged risk of harm and poor care.

Rating at last inspection:
The last rating for this service was Outstanding (Published 17 August 2018)

Why we inspected:
This inspection was brought forward due to concerns raised by staff, relatives and visiting professionals. Concerns included: unsafe staffing levels (particularly at night), people having unexplained bruises, a poor management culture, medicines concerns, dehydration, poor moving and handling of people, an unsafe analysis and response to incidents, cleanliness and not following infection control procedures, lack of activities, delays in care and people appearing unkempt. We received multiple concerns that the standards of care had reduced since our previous inspection. A decision was made for us to inspect and examine the risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement:
We have found evidence that the provider needed to make improvements in all of our key questions. We identified eight breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included regulations, 9, 11,12,13,14,16, 17 and 18. They had also failed to notify us of events occurring at the service. This allows us to monitor the safety of the service. This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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:
After the inspection, we received an action plan from the service. This explained how they intend to make required improvements at the service. We have also met with the provider, to see how they are progressing with this action plan.

We will continue to monitor information we receive about the service, until we return as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is 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?**<br>The service was not safe. | **Inadequate** |
| **Is the service effective?**<br>The service was not effective. | **Inadequate** |
| **Is the service caring?**<br>The service was not caring. | **Inadequate** |
| **Is the service responsive?**<br>The service was not responsive. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well led. | **Inadequate** |

# Kingfisher Court

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection team included two inspectors and an assistant inspector.

Service and service type
Kingfisher Court 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 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we had received concerns from visiting relatives, professionals and staff. Due to the level of concerns received, we decided to bring this inspection forward on our inspection planning timescales. Our inspection was largely planned around the types of concerns received. We also considered information that the provider had sent us since the last inspection.

The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We completed the inspection over two days. The first inspection visit occurred at night time to assess the safety of the service at night. The second visit was completed the following day. During our inspection, we carried out general observations of care and support. We looked at the interactions between staff and people who used the service. We spoke with twelve people who used the service and two relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven care staff, the registered manager, three senior managers and two visiting health professionals. We looked at the relevant parts of the care records of ten people who used the service. We also looked at two staff recruitment files and other records relating to the management of the home. This included audits, policies and incident records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance 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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Some staff felt unwilling to raise concerns about abuse at the service as they felt it would not be acted upon by the registered manager. Some staff felt they had been treated differently by other staff after raising concerns about abuse. There was limited guidance on how to raise concerns outside of the organisation. Due to this culture, there was a high risk that abuse would not be raised with the local authority or police. Staff had been aware of the CQC role in regulating services, so some concerns had been raised anonymously before our inspection.
- Staff told us that they felt unable to meet people's needs promptly and effectively due to low staffing levels. For example, one staff member explained that they had left a person in their urine due to a lack of time. This person was identified by a visiting professional to have urine burns on their skin.
- A record showed us that a physical altercation had occurred between two people at the service. There had been a failure to respond appropriately to this and inform the local safeguarding teams.

The poor systems in place to highlight abuse at the service, and incidents identified on inspection are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- There was a lack of records to guide staff on how to support people safely. For example, one person had been at the service for five weeks. Their pre-admission assessment identified complex needs, but staff had no guidance to meet these needs. Due to a high risk of skin breakdown, staff supported this person to reposition to relieve pressure. However, they did not keep records to ensure this was regularly done. This put the person at high risk of skin breakdown. Staff told us that the person's skin had recently deteriorated.
- Some staff were unaware how to navigate the electronic care system to read people's records and understand people's needs. Staff told us they did not read care records, and we found they had limited knowledge of people's needs. For example, one person required a restricted fluid intake due to medical reasons. However, staff were unaware, and one advised they routinely encourage double this recommended limit. This put the person at risk of ill health.
- There was an ineffective handover of information between staff. For example, we observed a person appeared to be choking on food in the morning. We were informed that they would now be observed when eating. However, in the afternoon, they were seen eating alone and the afternoon staff were unaware of the new risk.
- People were not supported to move safely at the service. One person required a hoist assessment, this had not been completed. Staff told us that the person had been carried by five staff members onto their bed. This put the person and staff at high risk of injury. Staff informed us that they routinely transfer people alone, when people require two staff members for safety.

● People were not protected from the risk of fire. There were inconsistent evacuation plans, and staff were not aware of what to do in the event of a fire. The fire service had told the provider about fire safety concerns one month before the inspection, this had not been acted upon.
● The environment was unsafe. Locked doors were left open, so people could access unsafe areas and hazardous materials were not locked away, which would put people at risk if swallowed.

Preventing and controlling infection
● The service was unclean. We observed urine stored in a communal fridge next to uncovered food, there was out of date milk in communal areas, the kitchen required a deep clean.
● Staff informed us that they do not remain off work for the required 48 hours after a potentially contagious illness. They attributed this to low staffing levels, and a feeling that they need to return to the service to support their colleagues. This action increases the risk of passing on infection to others.

Learning lessons when things go wrong
● Lessons were not learned when things went wrong. Incidents had repeatedly occurred, without effective action being taken.
● For example, before the inspection, we were informed of a person sustaining a burn (potentially from a hot drink). The provider advised they would review all care plans and improve the handover of burns risks. We identified that another person had been burnt (four weeks later). The planned review had not occurred, and the handover of information was again delayed. Following the inspection, we were provided with an updated burns care plan. We found it still required substantial improvement. There was prolonged risk of burns at the service due to a failure to act on incidents appropriately.
● Records showed us, and staff told us that the service had deteriorated since the last inspection. They advised they had raised concerns with the provider. The provider advised that they had begun to have increased oversight at the service. However, there has been a prolonged period of six months, where care has deteriorated, and lessons have not been learnt.

The unsafe risk management, lack of cleanliness and failure to learn from incidents is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were insufficient staff at the service, this put people at high risk of not receiving safe support.
● The highest staffing risk was at night time. Over-night rotas showed that sometimes five staff members covered three floors. On each floor, there were people that required two staff to support them. Staff told us that people needed two staff but were supported by one staff member. This was because they could not wait for staff from other floors to support. Staff were aware of the risks, but felt they had no choice.
● People also reported occasional low staffing in the day time. A day time staff member told us "Sometimes it is only 2 staff on a shift. We are running around like maniacs. I've had to leave people in their urine because I don't have time." A person also told us "They used to give me exercises, but they tell me they are too busy now."
● Records showed an increased number of incidents at night. Records attributed these incidents to low staffing levels. These records had been reviewed by the provider for the past six months and recognised that staff had been repeatedly concerned about low staffing levels. However action had not been taken to increase staffing levels.
●The provider and registered manager also acknowledged that staff had repeatedly asked for increased night time staffing. There was a prolonged failure to adequately staff the service at night, this had resulted in unsafe care. Since the inspection, they advised they have increased staffing numbers, we will assess the impact of this at our next inspection.

The low staffing levels are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were safely recruited to ensure that they were appropriate to work with people, for example staff had Disclosure Baring Service (DBS) checks to ensure they were of good character.

Using medicines safely

● Medicines were managed safely at the service. People received medicines as prescribed.

● Medicines were stored safely and securely.

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 this key question was rated as Outstanding. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
- Records were not always kept of what drink people consumed. Where records were kept, we observed that some people had inadequate drinks offered. One person had been admitted to hospital with dehydration.
- People had specialised diets due to a risk of choking, however care staff and kitchen staff had incorrect or incomplete guidance on people's dietary needs. We observed people eating incorrect food texture for their health condition, this put them at risk of choking.

This failure to ensure people received appropriate nutritional intake, is a breach of Regulation 14 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 particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's ability to make decisions were not always assessed in line with the MCA. Where their decision making had been assessed, assessments were of poor quality and did not provide sufficient explanation.
- Some people at the service had DoLs authorisations in place. The conditions related to these authorisations had not been met. One person's authorisation had expired and had not been applied for in a timely way.
- There was a lack of oversight of DoLs to ensure that people's human rights were respected and upheld. Staff were unaware of who had a DoLs in place.

There was a failure to make sure people's decision making was assessed and their rights upheld with the MCA, there was also a failure to ensure those people subjected to a DoLs were supported in a legal and appropriate way. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's needs were not assessed in line with current guidance. There was limited guidance in place to guide staff on how to support people's needs, where needs had changed then reviews were not completed in a timely way.

●Nationally recognised risk assessment tools were not completed in an accurate way. This can impact on the type of care provided. For example, one person was weighed regularly however the tool was marked as 'unknown' for a history of weight changes. The inaccurate use of the tool can impact the care quality.

Staff support: induction, training, skills and experience

● Staff were not sufficiently trained to provide effective care. For example, Only 41% of staff had training in dementia awareness and 53% had training in nutrition and wellbeing.

● Staff told us that the induction did not adequately prepare them for their roles. One staff member said, "You get thrown in at the deep end and work it out."

● Some staff had poor knowledge on how to use the electronic care records system. Their lack of system knowledge prevented them accessing and updating care records. This meant their knowledge of people at the service was often incorrect.

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

● People told us that medical advice was sought promptly. However, this medical advice was not clearly documented to guide effective support. For example, a professional had advised that a person was repositioned every two hours. This was not clearly documented to guide effective care.

● We found the service did always follow professional advice. For example, one person was medically advised to not lie on their back. This person was repeatedly positioned onto their back which would impact their health.

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

● Kingfisher Court is a purpose-built building. There was adequate signage and lighting to navigate around the home. Rooms were of a good size to promote safe use of equipment.

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 this key question was rated as outstanding. At this inspection this key question has now deteriorated 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

- People told us that they have to wait for support, one person said "If I press my bell, it can be up to 15 minutes so I'll end up wet because I can't wait". Staff supported this and advised that due to low staffing levels, people are often incontinent and left in urine for long periods. We observed one person had skin damage from urine. Delays in care resulted in an undignified service.
- We observed minimal social interaction between staff and people, interactions were focused on meeting care needs. When interactions occurred, staff treated people in a respectful way.
- Our previous inspection found staff had gone out of their way to learn about people's history. We found that staff now had a limited knowledge of people's life history, people had lived at Kingfisher Court for over a month and little effort had been made to get to know them.
- A relative told us that there had been a marked deterioration in staff's caring attitude since the last inspection.

Supporting people to express their views and be involved in making decisions about their care

- A person said, "New staff don't know where my things are. They aren't introduced to me now." We found people's preferences were not recorded and staff had limited knowledge of people's preferences.
- People told us that daily decisions were asked of them (like when they would like to go to bed). Staff advised that there has been some pressure from management for people's routines to fit in with the service (for example all getting up at the same time). Staff advised they are still working hard to follow people's daily choices.

Respecting and promoting people's privacy, dignity and independence

- People told us that staff respect their privacy. We observed that staff knocked on people's doors and asked for permission before providing support.
- The complaints process was not private and did not follow General Data Protection Regulations. There was an open comments book on reception, we observed complaints related to people's private health needs. This did not respect the person's privacy.
- People were not always treated with dignity. This is because support was either delayed, or not offered promptly. This lack of dignity impacted on people's wellbeing.

Inadequate

# 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 as outstanding. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Improving care quality in response to complaints or concerns

- Where complaints had been made, they had not been responded to in a timely way. One complaint took two months to be responded to (the provider had a timescale policy of 20 days)
- Complaints were not consistently recorded and followed up. For example, staff had recorded in care notes that a relative found their loved one unclean. There was no formal follow up to assess why this person was unclean, no action taken to ensure it did not happen again and no feedback to the complainant.
- Responses to complaints were inadequate and did not address all the issues raised. For example, a relative was concerned about unsafe moving and handling. This part of their complaint was not responded to.
- Complaints had been made to the service, but not resulted in improvements. We noted complaints for delayed toileting support, burns, moving and handling, and poor communication with relatives. These were ongoing issues at the inspection, and there had been a failure to address global issues once an individual complaint was received.

There was a failure to respond to complaints appropriately. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care was not always personalised. For example, a person who could not communicate clearly had no care plan to guide staff on how to communicate with them. Staff advised they could not communicate clearly with them and knew little about the person.
- Where care plans had changed, it did not always include the person's preference. For example, a person at risk of falling had a motion sensor in place, which would alert staff that they were moving. There was no record that this person was aware of the sensor or had given permission for the potential intrusion on their privacy.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service was not meeting the legal requirements of the AIS. People were not always given information

in a way that they can understand. For example, one person was unable to talk however staff had no guidance on how to communicate with the person. Staff were unsure of the persons communication needs.
● People's communication needs were not clearly documented to guide staff.

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 were less activities staff at the service since our last inspection. Records showed us that people had complained to the service about a resulting lack of activities at the service.
● People told us that they remained concerned about the lack of activities. We observed that a few people were taken into the community, but people were otherwise sat in communal areas with minimal social stimulation.
● One staff member said "The third floor is the worst. It is the forgotten floor. People are bored."
●The provider advised they are in the process of recruiting new activities staff. However, the long delay has impacted in people's social engagement.

There was a lack of personalised care at the service, this meant peoples preferences and individual needs would not always be responded to. There was also a lack of activities to promote wellbeing. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● Care plans were not of a consistent quality to cover people's holistic end of life wishes.
● As stated in this report, there has been a lack of effective professional working. People at the end of their life require a high level of multi-professional involvement. The current communication and recording of professional feedback would put these people at high risk.
● Staff do not currently respond to people in a timely way. If people were to require end of life support, there is a risk that this support would not always be dignified or responsive to changing needs.

Inadequate

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a new registered manager since our last inspection. Staff reported a marked deterioration in leadership at the care home. Staff reported a poor relationship with the registered manager and felt that the wider management team were also unapproachable and unsupportive.
- Staff advised that they had raised concerns, but these had not been responded to. Staff felt that they would no longer raise concerns as it was ineffective, and they would be treated differently.
- We observed, and people/staff told us that the person-centred atmosphere of the home had changed. One staff member said, "When I started I was told it was all about the residents, it was a 24 hour a day 7 day a week service. People could get up when they wanted and go to bed when they wanted. It's not like that now."
- People no longer had good outcomes at the service. We identified multiple breaches of regulation, which had been occurring since the last inspection and put people at high risk of harm.

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

- We found that complaints were not responded to appropriately at the service. This resulted in a lack of improvement at the service.
- Since our inspection, the provider has provided a clear action plan on how they intend to make improvements at the service. This includes the recruitment of a new registered manager. We have received copies of communication showing that the provider has been open in its communication with staff and relatives since the inspection. We will assess if required improvements have been made at our next inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider advised that they had begun to recognise a deterioration in the service a few weeks prior to our arrival. They had therefore begun increased oversight of the service. Records showed us, and people told us that deterioration had occurred for the last six months. While it is good that the provider had begun increased oversight, there has been a long delay in recognising the deterioration at the service. This has prevented effective change.
- Staff were not always aware of their responsibilities at the service. For example, staff were responsible for updating records at the service. This would then provide clear guidance on people's needs. Those staff

responsible for updating records advised they were unaware of how to do this or what was expected of them.
● Records were not kept updated, to ensure staff were guided on how to complete safe and effective care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was a lack of guidance about people's individual needs. Staff had limited knowledge on people's diversity or routines. One person could not easily communicate, staff were unsure how to communicate with them and there had been no attempt to source this information. This put the person at high risk of isolation.
● Resident's meetings were held but were ineffective at instilling change. For example, in January and April relatives had raised concerns about reduced standards of care. This included low staffing levels and the reduced amount of activities. We observed that these concerns were still on-going, and these concerns had not been resolved.

Working in partnership with others
● People at the service felt that medical attention would be sought as needed. However, we identified that professional advice was not always documented or followed.
● Not following professional advice put people at high risk of unsafe and ineffective care.

Continuous learning and improving care
● Audits and governance had proved ineffective at addressing the risks at the service. For example, incidents were recognised to increase at night. However, the action plan for the previous six months had requested that staff be more vigilant. The action plan had not recognised the reduction in staff numbers, and complaints from relatives, staff and people about unsafe night time staffing levels.
● Where incidents had occurred, the provider's analysis of these incidents was not thorough. For example, one person was found after a fall. The provider's analysis had not recognised that the person should not have been left alone. The failure to adequately review incidents meant that people were not prevented from future harm.
● A month before our inspection, the fire service had raised similar concerns about fire safety to the provider. A month after our inspection, the NHS identified ongoing concerns about the cleanliness at the service. The provider has not addressed risks in a timely way.

There was a lack of effective governance at the service. The concerns that we identified had not been resolved from the management team. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the inspection, the provider has advised that they have improved oversight at the service. They have also advised that they intend to change management structures. The impact of this will be assessed at the next inspection.
● It is a legal requirement for the provider to notify us of events that occur at the service. This is so we can monitor the running of the service. We had not received notifications about incidents that had occurred. For example, we had not been informed of an altercation between two people that lived at the service.

The failure to notify the Care Quality Commission about incidents that occur at the home is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive care according to their routines and preferences. Staff had limited knowledge of people's individual preferences. People therefore did not receive person centred care |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People's ability to make decisions for themselves was not always assessed in line with the Mental Capacity Act (2005). The service did not follow the requirements of the Deprivation of Liberty Safeguards, so people were at risk of being restricted without lawful consent. |

| 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<br><br>We observed that people had experienced undignified and unsafe care. Staff felt unable to raise concerns, and concerns that had been raised in complaints had not been adequately responded to. |

| Regulated activity | Regulation |
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| Accommodation for persons who require nursing or | Regulation 14 HSCA RA Regulations 2014 Meeting |

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| personal care | nutritional and hydration needs<br><br>People were at risk of dehydration. People's dietary needs were not always documented, and people did not receive the correct diet which put them at risk of choking. |

| Regulated activity | Regulation |
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| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>Complaints were not responded to in a timely and effective way. This meant that concerns at the service were not addressed appropriately. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were insufficient staff to meet people's needs in an effective and person centred way. Support was also delayed which impacted people's dignity. |