Care One Limited

Abbey Care 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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Abbey Care Home is a residential care home providing personal care to people aged from 18 to 65 years and over who may have mental health, learning disability, physical disability or dementia. The service can support up to 20 people in one adapted building, over three floors. The service is centrally located providing easy access to local community facilities and transport. At the time of the inspection there were 16 people accommodated.

People's experience of using this service and what we found

Leadership, management and governance arrangements were poor and did not demonstrate the service was well led, people were safe, or their care and support needs were being consistently met. Quality assurance systems were ineffective and unreliable in identifying shortfalls, and where improvement was needed. People's safety and welfare was compromised and there was a lack of understanding of the risks and issues and the impact on people using the service.

We identified significant shortfalls with how the provider and management team were responding to the COVID-19 pandemic. Although policies reflected government guidance, safe processes were not being followed. Areas of the home were not clean and measures to limit the risk of cross infection were being neglected.

Risks were not identified or managed effectively to keep people safe. The physical environment, including fire safety, maintenance work and health and safety precautions had not been monitored effectively to protect people from the risk of harm. This included a Velux window on the second floor without an opening restrictor and concerns about the integrity of existing restrictors and frames.

There were elements of a closed culture in the home. There were institutionalised routines and limits on how people spent their lives due to poor staff training and oversight. There was a lack of personalised care that ensured people's physical, mental and emotional needs were being met. 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. Staff did not have the opportunity to develop more skills to ensure their understanding and there were no systems to demonstrate competency.

People were not valued and treated with dignity and respect, especially those people living with dementia or mental health needs. We found concerns raised prior to our inspection about poor practice were correct. This included decisions made by the provider and management team, which increased risks without adequately exploring alternatives, for example with other professionals.

Care plans did not reflect person centred care. An effective system was not in place to ensure there were enough staff on duty to support people to follow interests, take part in social activity and access the

community.

People were not provided with regular access to meaningful activities and stimulation appropriate to their needs, to protect them from social isolation and promote their wellbeing.

Recruitment practices did not fully explore new employees experience and suitability for the role.

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

Rating at last inspection
The last rating for this service was Good (published 8 March 2018).

Why we inspected

This was a planned inspection based on the previous rating and prompted in part due to concerns received from whistle blowers. The concerns were about poor care, staffing, lack of training and skilled staff, poor cleanliness and hygiene, lack of dignity, respect and quality of life for people living at Abbey Care Home. A decision was made for us to inspect and examine those risks. We carried out an unannounced comprehensive inspection.

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.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abbey Care Home on our website at www.cqc.org.uk.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to fire safety, infection control, risk, environment, staffing, staff training, dignity and respect, personalisation, leadership, management and governance.

Please see the action we have told the provider to take at the end of this report.

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
We will continue to monitor information we receive about the service. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
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.

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? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not caring	**Inadequate**
Is the service responsive? The service is not responsive	**Inadequate**
Is the service well-led? The service is not well led	**Inadequate**

Abbey Care 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 Care Act 2014.

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
The inspection was carried out by two inspectors.

Service and service type
Abbey Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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.

We visited the home on 10 and 11 August 2021.

What we did before the 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 this information to plan our 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 spoke with four people who used the service about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, senior care workers, care workers and the cook. 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 reviewed a range of records. This included five people's care records and medicine records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, training data, quality assurance records, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke and met with external stakeholders and other regulatory bodies.

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.

Preventing and controlling infection

- We were not assured the provider and registered manager were making sure infection outbreaks could be effectively prevented or managed.
- Multiple areas of the home were unclean and unhygienic. Fittings in communal bathrooms/wet rooms were in poor condition making it difficult to ensure they were clean and safe to touch.
- Staff were not using Personal Protective Equipment (PPE) safely.
- People were not provided with toilet rolls, hand soap or paper hand towels in communal toilets. We observed people using the toilets and not having access to hygiene equipment to maintain personal hygiene.
- The outside laundry was cluttered, unclean and unhygienic. Paint was peeling off the walls and did not allow for effective cleaning; paint was peeling off the walls. There was no effective system in place to limit cross-infection when completing laundry for people.
- The laundry room was used for visitors to put on and take off (donning and doffing) their PPE. The provider could not demonstrate the laundry room was assessed as being a hygienic and suitable area for visitors/relatives to enter to don and doff PPE.
- PPE was not being disposed of safely. PPE including aprons and gloves were disposed of in unlined and open bins throughout the service. Two clinical waste bins were located outside. Poor systems for disposal of PPE and sanitary waste placed people, staff and visitors at risk of infection.

Assessing risk, safety monitoring and management

- The physical environment posed risk to people's health and safety. The safety of windows had not been risk assessed, one window on the second floor did not have a restrictor to restrict it from fully opening and prevent risk of harm. Where protective paint had peeled away from window frames, the wood was cracked and decayed, glazing putty had fallen out which meant the single paned windows were no longer secured. This posed a significant safety risk if the panes were to fall out. Not all radiators had protective coverings to protect people from burns if fell against. Older people's skin is more fragile and sensitive to heat.
- The last fire risk assessment was carried out in 2016 and subsequently reviewed by the registered manager. They could not demonstrate to us they were skilled and competent to complete this and had failed to ensure all actions and recommendations had been completed and sustained to ensure fire safety. The basement was full of potentially combustible items, from floor to ceiling. The area under the stairs and next to the escape route was also cluttered.
- Personal emergency evacuation plans (PEEPS) were limited in detail and did not consider essential information for a safe evacuation such as the person's level of awareness and co-operation, vision or hearing impairment or any medicine prescribed that may cause drowsiness.
- The provider did not have a current working emergency escape plan to aid a safe and prompt emergency

evacuation in the event of a fire, detailing assisted means of escape and evacuation strategies with escape time and travel distances.
● Staff told us they had completed online fire safety training but were unable to tell us what they would do to carry out a safe evacuation plan and procedure, including practical aspects of evacuation procedures. There was no evacuation equipment to assist with the stairs. Records did not show this had been fully assessed to consider the risk.
● Moving and handling practices were not managed safely which exposed people to risk of injury. We saw a staff member supporting a person with no sight to move around the service by holding both their hands and pulling them whilst walking backwards. This person advised they did not have a walking stick and one had not been sought for them.

All of the above is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we reported our findings to the local Fire and Rescue service. We also shared our findings with the local authority and asked the provider to tell us what they would immediately do to address the risks.

Systems and processes to safeguard people from the risk of abuse
● Prior to this inspection we received information of concern from whistle blowers stating their concerns would not be listened to by the management team. Our inspection substantiated many concerns raised and our findings are included within this report.
● The provider and management team did not demonstrate a robust approach to ensuring concerns, including safeguarding and whistle blowing's, were individually considered and addressed. The service has received some malicious and unsubstantiated allegations. However, they failed to acknowledge and address other safeguarding concerns raised anonymously by whistle blowers, dismissing them all as malicious.
● The provider and the registered manager did not demonstrate they had a good understanding of their safeguarding responsibilities. They had allowed practice which left people exposed to degrading treatment without recognising it or exploring alternative strategies. For example, people had to ask for toilet paper, soap and hand towels before using the toilet.
● The provider did not have effective systems to protect people from behaviour that presented a risk to themselves, or others. Risk management plans lacked guidance for staff on recognising and responding to early signs of distress and anxiety. Staff did not have the information needed to intervene effectively through personalised de-escalation techniques or other agreed good practice approaches, to reassure people.
● Information recorded in individual's 'behaviour monitoring' records focused on impact and risks to staff. The actions recorded as taken by staff, in one case, was to scold as if a child. This showed a lack of understanding of the person and awareness of behaviours being a form of communication or expression of distress and anxiety.
● Staff completed 'behaviour monitoring' records when people became distressed. Management did not monitor or review the records to identify causes for their distress. Records showed for one person their distress was triggered by staff attitude and approach and for another not having access to cigarettes. Opportunities were missed to identify behavioural cues and for staff to learn possible positive interventions, which could be used subsequently in similar situations to avoid distress and risk of harm.

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

Staffing and recruitment

● Recruitment practices were insufficient to protect people from the risk of unsuitable staff. Previous employment references and reasons for dismissal were not fully explored and recorded by the provider and registered manager. Appropriate support and supervisions were not provided for new staff, where needed, to assess their suitability for the role.

This is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not enough staff with the right skills and competencies to provide the right level of person-centred care and this affected the quality of care people received. The level of staffing was not linked to a need's assessment and staff were not deployed sufficiently to ensure people were supported to promote their wellbeing. There were an absence of inclusive activities and people were not supported to access the community.

● There were no contingency arrangements to address unforeseen staff absences or annual leave.

● The service was not clean and in the absence of a cleaner a care staff member was seen to clean the communal toilets before their shift.

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

Learning lessons when things go wrong

● There were no clear processes in place or a culture to learn lessons and improve practice.

● There was a reluctance from the management team to acknowledge concerns and investigate.

● There was no record of actions and lessons learned taken forward from recent concerns raised about the service.

● The registered manager was unable to demonstrate how they identified any trends or themes in incidents across the service, and where improvements were needed in order to minimise risks of similar incidents.

Using medicines safely

● There were no night staff trained and competent to administer prescribed medication. This meant people could not receive medication at night if it was needed. Night medication was given by day staff before they completed their shift at 8pm, therefore earlier than intended by the prescriber. The impact of this practice had not been considered in terms of efficacy of medication, timeliness between doses and 'as and when required' prescribed medicines.

● Medicines were managed safely, and senior care had systems in place to detect errors and take prompt action if errors found. Medicine administration records were completed correctly.

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 good. 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience.

- There was a diverse mix of people living at the service who had a wide range of specific and complex needs relating to either mental health, learning disability, physical disability (including sensory loss) or different types of dementia. Training in place for staff did not reflect these needs or explore how care would best be provided for individuals. The approach was institutionalised, generic and task based. For example inflexible routines for baths/going out, lack of interaction between meals, talking disrespectfully or as if to a child.
- Records and observed practice did not demonstrate professional development or specialist understanding linked to the needs of the people they cared for.
- There was no monitoring process to assess staff knowledge and competency whilst care was being delivered by staff. This meant the management missed opportunities to identify training needs and /or improve practice.
- Prior to our inspection we received information raising concerns about moving and handling training. A senior staff member delivered moving and handling to staff and assessed competency. However, their training certificate was no longer valid and their knowledge was no longer current. This had not been identified by the management team and so they were unable to demonstrate if staff were being trained correctly and safely.
- The registered manager and provider (Director) could not demonstrate they had the skills, expertise or competence to carry out risk assessments such as health and safety and fire safety. Without this they could not show how they protected the people they cared for, as far as possible, from unsafe practices and risks.

This is a breach of Regulation 18 (Staffing) 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.

● The service was not always working within the principles of the MCA. Independence was not promoted. Management and staff did not empower people to make as many decisions as they could and did not support them in the least restrictive way.
● Assessments for some people were contradictory and did not demonstrate a good understanding by the assessor.
● Assessments showed best interest decisions were not based on the person's ability to make that specific decision. Least restrictive options were not considered and advice from skilled professionals was not sought.

Adapting service, design, decoration to meet people's needs
● The service did not provide an enabling environment for people living with dementia or with sensory loss. People were not assisted with recognition and orientation. There was a lack of signage to provide visual clues, prime colours were not used for high definition and the lighting was either poor or did not work in some areas.
● There was a lack of handrails throughout to assist people with visual impairment and poor mobility.
● A person with no sight had a high definition blue toilet seat in their bedroom ensuite toilet facility. However, this seat was not attached to the toilet, this posed a risk of falling and injury to the person who would not see the seat was not secure.
● The showers in two wet rooms did not have a shower head attached and therefore were not useable. The provider said they were unaware of this.
● Furnishings were not suitable to meet people's needs. For example, in one room the chest of drawers were broken, the front of the bottom drawer had fallen off, the headboard to the bed was broken and had fallen behind the bed, the divan was stained and the light bulb was missing at the front of the room by the door.
● Bed linen, towels and flannels were worn and threadbare and in urgent need of replacing. We were advised they were not replaced due to specific risks relating to one person. There had been no consideration given to the impact on others or exploration of alternative approaches.

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

Supporting people to eat and drink enough to maintain a balanced diet
● The provider did not ensure people had enough to eat and drink throughout the day. Drinks and snacks were restricted. The management team explained there used to be a communal drinks station, this was no longer in use because one person removed items from it. They had not explored ideas about to manage this situation so people who were able/wanted to help themselves to a drink were able to do so.
● Fresh fruit and snacks were not freely available or accessible. We were told by the cook and the registered manager this was because people did not have clean hands, so they have to ask.
● We found food stock was limited to the remainder of the week's planned menu. The cook told us shopping would be bought by the provider the next day, Wednesday.
● Whilst food stock may be relatively low just before the next delivery there were no additional food stuffs, fruit or snacks if someone asked for them or wanted something other than the planned meal.

● A staff member told us some people buy items such as crisps out of their own money and keep them in their rooms. "We don't give them too much for their wellbeing, we don't want people to put weight on." However this was not linked to plans of care, so did not take account of people's needs or risks relating to eating and drinking.

This is a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There was a lack of proactive engagement with specific professionals who could support individual people with complex needs. The service was not ensuring they were up to date with best practice or engaged with professionals/support to support better lives for people.

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 good. 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; the provider and management caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- The provider and management did not support staff to provide care and support in a way that ensured people's dignity, privacy and independence, or supported their self-respect.
- The provider and management did not allow toilet rolls, hand soap or hand towels in communal toilets and bathrooms on any floor because one person put items down the toilet. The impact on people's dignity was not considered and alternative strategies were not explored to manage the situation. This was an unnecessary infringement on people's dignity and ability to remain independent.
- Peoples bedrooms were sparse and not homely. Divan beds were old and stained. People were not provided with individualised bed linen, towels and flannels. Communal bed linen, towels and flannels were old, worn and frayed and many towels and flannels had holes. This did not demonstrate a caring approach, by showing vulnerable people they were valued and respected.
- People looked unkempt, their hair was not brushed and they were unshaven. There was only one working shower room and people were showered according to a rota.
- Some staff did not observe or promote people's privacy and dignity; one staff member was heard to ask a person loudly in the lounge, in front of others, '(Name) do you need a wee?' and 'I need to check your pad!' This person appeared upset and irritated and responded by swearing at the member of staff.
- Staff did not receive time, training or adequate support to deliver effective care in a compassionate and supportive way. Staff provided basic support and social interaction with people was reserved primarily for when staff were completing a task. This did very little to promote people's independence, choice and wellbeing.

This is a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not supported to make day to day decisions about what they wanted to eat or what they wanted to do.
- We were not assured people were involved in making decisions about their care or supported to express their views.

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 good. 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.

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

- People's care and support was not planned and delivered in an individualised or personalised way. Staffs approach to delivering care was task led, routine based and not consistent and responsive to people's needs. Staff told us they did not consult with people's care plans nor did they participate in the planning of their care.
- Care plans did not reflect how people's dementia, mental health or long term health condition impacted on their day to day living, or the type and level of support they needed. People's strengths, levels of independence and quality of life were also not reflected. Significant and relevant information about people's personal history, individual preferences, interests, hobbies or aspirations were not used to inform care and guide staff on how to support them in the most effective way.
- Care plans were vague in relation to the triggers, understanding and personalised support needed by people who at times their distress led to increased aggression, anxiety and agitation. Staff did not know how to recognise, respond, manage or support people. Monthly evaluations of peoples care records did not review what worked well or include revised and effective communication and management strategies.
- Although there were records to show oral health had been assessed it was unclear how aspects of people's personal care needs were being supported. Toothpaste was not found in people's rooms, and there were no signs that toothbrushes had been used as they were dry and brittle. We saw a person's razor encrusted with hair and generally unclean.
- Dementia is a terminal illness. Care records did not demonstrate the stage/development of illness or how end of life care had been planned for in a way that ensured personal needs and preferences at that stage of people's life had been considered fully with the help of family, friends, advocates or support workers.

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 following the Accessible Information Standard. Information for people such as menu, resident meeting minutes and signage were not provided in appropriate formats to enable people with dementia, impairment or sensory loss to understand.

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 no arrangements in place to support people with meaningful activity. People told us they were bored and had nothing to do. When asked how they spent their day one person said, "This is it, sitting here, waiting for a newspaper that should be here, then watching a bit of television." They explained how they were not happy and said, "I would call it a 'not' care home". Another said, "Days just roll into one, I do nothing, it's miserable. We never go out."
● Some people had little or no contact with anyone for very long periods of time. One person sat alone in their bedroom all day except for meal times. The management team could not demonstrate how the person was supported to lead a meaningful life, for example when they had last left the home or if any other activities had been explored. This issue had also been identified at a previous inspection but no progress had been made.
● People told us they were not given the opportunity to go out into the community, which was something they really missed doing. Management told us people didn't want to go out. They were unable to demonstrate how this had been assessed.
● Throughout our inspection people were observed to sit around in communal areas all day. There was an over reliance on the television, but few were actively watching, or able to watch.
● There were limited resources available around the home to interest and occupy people who were living with dementia. For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental stimulation. People were left to their own devices which resulted in incidents, heightened anxiety levels or social isolation.

This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns
● We and commissioners of care had received information that concerns had been raised by staff but they had not been acknowledged or addressed by management. The provider and registered manager told us they had not received any concerns or complaints. Although aware of concerns raised by whistle blowers and by safeguarding reports, they did not use the opportunities to demonstrate how matters were resolved, and outcomes shared with people living in the home, staff, relatives or others, in an open and transparent way.

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 were elements of a closed culture within this service. The leadership team did not promote a positive person-centred culture and the service provided failed to achieve good outcomes for people. There were no clear set of values, aims or aspirations which staff could follow or be a part of to improve outcomes for people.
- Peoples needs were overlooked because diversity and equality were not understood, acknowledged or respected by the leadership team. Staff were not supported to promote people's rights, experiences and wellbeing and people were not empowered to maintain independence, choice and preference.
- We observed examples of institutionalised practice which was undignified and disrespectful. People had little control over their lives because there was a lack of opportunity to make choices about how to spend their day, when they had a shower, what to eat or when to go out. Where opportunities to do so were identified the management team either did not recognise it or had not taken action to facilitate it.

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

- There was a lack of leadership, oversight, direction and effective role models to lead and support staff. A director of Care One Ltd was also one of the registered managers. They visited the home regularly and also provided telephone support to another registered manager who worked full time at the home.
- There was no clear structure of responsibilities to ensure effective oversight of the safety and quality of care delivered.
- The provider and registered managers were failing to robustly and adequately assess the quality and safety of the service, to drive improvement or find where lapses were occurring.
- There were no formal audits or analysis undertaken or scheduled to monitor the safety and suitability of the premises, there were no systems in place to ensure an effective infection control programme or ensure fire safety was regularly reviewed and assessed by competent staff.
- Although checklists were used, they were tick box based and did not reflect the experiences of people living at the home. They did not demonstrate any check on the quality and impact of care being provided.
- A more effective learning and development plan was needed to enable staff to develop the skills and expertise needed to carry out their roles more effectively. In particular, dementia, mental health, communication skills, person centred care, diversity and engaging with people in purposeful activity.
- When we discussed our concerns with the provider and registered manager, they showed limited understanding of their responsibilities and what good care looked like. One of the registered managers had

limited experience in managing a registered service and was not supported effectively to develop in their role. They had no effective/monitored development or support plan in place.

● The provider had engaged a consultant, but it was not clear what level of involvement they had with oversight, governance and quality assurance of the home. The provider, registered managers and consultant had not identified the levels of concern at this inspection and therefore we were not assured the systems in place were robust enough to identify and resolve problems independently. The director/registered manager responded to our urgent concerns but these lacked detail and did not demonstrate understanding of the seriousness for the safety and protection of the vulnerable people cared for.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager was unable to demonstrate how the views and experiences of people were explored and how involvement in their care was promoted. There were no arrangements in place to show how comments or concerns received from people were considered or managed to drive improvement.

● Minutes of staff meetings were written with an aggressive tone and the content was disrespectful and de-valuing of staff. We discussed our concerns with this type of recording with the provider and how this can be perceived by staff as bullying and does not demonstrate an open, transparent and supportive leadership.

● There was a blame culture and after the inspection staff members told us they were being blamed for the failings of the service; staff were not empowered to be part of the solution, by becoming actively involved in the improvement and development of the service.

Working in partnership with others; Continuous learning and improving care; 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

● There were no systems in place demonstrating if/how the provider worked with external agencies in order to keep up to date with developments in mental health, dementia care and sensory technology and developments. This would help to ensure care and support delivered was appropriate, in accordance with best practice and drive continuous improvements for a quality, safe service.

● We received feedback the management team was not approachable, and issues were not dealt with.

● There was not a culture which proactively identified issues and learnt from them.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Peoples care was not personalised and specifically tailored to meet all their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity, privacy and independence was not respected and promoted.

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 People were not being protected from the risk of abuse and were exposed to degrading treatment. People were not supported properly when they were distressed and anxious.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not assured enough to eat and drink throughout the day.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014

personal care	Premises and equipment The service was in a poor state of repair. Furnishings were broken and of poor quality. Bed linen, towels and flannels were not fit for purpose. The service did not provide an enabling environment. There was a lack of equipment to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective quality assurance systems that were operated effectively to identify shortfalls and where improvement was needed, and take action to improve the service and outcomes for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were insufficient to protect people. Information from previous employment were not always sought and reasons for dismissal were not explored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff with the right skills and competencies to provide the right level of care to meet people's needs. Staff learning and development was insufficient, care delivered was not knowledge based and best practice.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm from poor infection prevention and control, health and safety and fire safety. People were at risk of harm from poor moving and handling practices.

The enforcement action we took:

We took urgent action and imposed conditions on the providers registration to force improvement.