Akari Care Limited

Felmingham Old Rectory

Inspection report

Aylsham Road
Felmingham
North Walsham
Norfolk
NR28 0LD

Tel: 01692405889

Date of inspection visit:
01 May 2019
03 May 2019

Date of publication:
26 September 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Felmingham Old Rectory is a residential home that was providing personal care and accommodation to 28 people at the time of the inspection. Most were adults aged over 65 although one service user was under this age.

People's experience of using this service
People did not consistently and routinely have their basic care needs met. Their dignity was compromised, and they lived in a home that was odorous and required repair. Equipment was not accessible to them as they needed it and they were sometimes supported by staff who were inattentive and dismissive.

People had not been involved in the planning of their care and the decisions around those. They had not been consulted on the service they received or asked for their opinions. Where people lacked capacity to make their own decisions, actions had not been consistently taken to uphold their rights. People did not receive a service that was caring and individual to them. People were not treated in a consistently respectful manner and the care and support they received did not consider their past lives, feelings and aspirations.

Full recruitment checks had not been completed on potential staff and the service was running on a high number of agency staff which compromised continuity of care. People were supported by staff that were demotivated and did not feel valued or listened to. Staff were not fully trained, supported or supervised and lacked direction. We saw that there were enough staff on duty but that they were ineffective and that the home was chaotic. This impacted on the poor service people received.

The risks to people, both individually and regarding the environment, had not been fully identified or mitigated and people were placed at risk. The environment was poor. We found it to be unclean and in need of repair. People had been placed at risk of infection and this was demonstrated by the high number of people either confirmed as having an infection or showing signs of an infection. The service had failed to report this to Public Health as required.

People's nutritional needs were not met, and the service failed to adhere to good medicines administration and management practices. People had received input from health professionals, but their recommendations were not consistently followed by staff putting their health and wellbeing at risk.

The service had unstable management and the governance systems in place were ineffective. The provider had long identified concerns within the service but failed to make improvements. There was no registered manager in place as required by their registration with the Care Quality Commission (CQC). The provider had failed to protect people in their care.

Rating at last inspection
The service had been rated as good in all areas at its last inspection. The report was published on 10

November 2016.

Why we inspected
This was a comprehensive inspection and had been planned for later in the month of May 2019. However, due to receiving serious concerns from other stakeholders, the inspection was brought forward.

Enforcement
Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals 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 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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.

Felmingham Old Rectory

Detailed findings

Background to this inspection

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

The comprehensive inspection was brought forward in response to information of concern that we received from a number of stakeholders.

Inspection team
The inspection site visit was completed over two days. On the first day two inspectors, a medicines inspector, an assistant inspector and an expert by experience was in attendance. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, specifically for older people. The second day of the inspection was completed by one inspector and an inspection manager.

Service and service type:
Felmingham Old Rectory is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service can accommodate up to 41 people in one adapted period building. At the time of this inspection, 28 people were receiving care and support. Two of those people were in hospital. Most people residing in the service were living with dementia.

The service did not have a manager registered with the Care Quality Commission in place at the time of the inspection. This means the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided.

An interim manager was in post at the time of this inspection. They had started three days prior to our inspection visit. We refer to them as the manager throughout this report. A senior management team of

three others had been brought in from another of the provider's services to assist the interim manager. They had been in the home approximately four weeks.

Notice of inspection
This was an unannounced inspection and the provider was not aware of our inspection prior to our visit on 1 May 2019. The provider was aware we needed to return for a second day but was not made aware of when this would take place.

What we did
Prior to our inspection we reviewed and analysed the information we held about this service. This included reviewing statutory notifications the service had sent us. A notification is information about important events which the provider is required to send us by law. We also viewed the information sent to us by stakeholders including the commissioning body.

A Provider Information Return (PIR) is key information providers are requested to send us on their service, what they do well and improvements they plan to make. The information helps support our inspections. We reviewed the PIR we had requested, and received from the provider, in August 2018.

We spoke with ten people who used the service and briefly with one relative. We also spoke with two visiting professionals. In addition, we spoke with the regional manager, interim manager, two staff from the management team brought in from one of the provider's other locations, two senior care assistants, one care assistant, a chef and two domestic assistants.

We reviewed the medicines administration record (MAR) charts for 15 people and spoke with five members of staff about these. We also reviewed the care planning documents for eight people who used the service. Documents associated with the management of the service were also viewed.

After our inspection, we asked the provider for further information and this was received within the requested timescale. These were reviewed and included as part of this inspection.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely; Assessing risk, safety monitoring and management
• Medicines were not managed safely and did not adhere to good practice guidance.
• Medicines were given by staff and recorded on Medicine Administration Records (MAR charts), however, we noted some gaps and discrepancies where records did not confirm medicines were given to people as prescribed. In addition, records for the reasons why medicines were not given to people were not always clear and accurately completed.
• When people refused their medicines prompt and appropriate action was not always taken to contact the prescriber and establish further actions.
• Records of the application of medicines prescribed for external application such as creams and emollients were not always completed by staff and containers were not always marked to show staff when they were opened so that they could be disposed of when their shelf lives had expired.
• Observations of staff showed that at the time of inspection they gave people their medicines safely, however, we noted that medicines were prepared in a busy area of the home with the potential for distractions. In addition, records showed that not all staff had been recently assessed for their competency to handle and give medicines safely.
• There was guidance to help staff give people their medicines prescribed on a when required basis consistently. However, for a person with more than one pain-relief medicine prescribed on this basis there was insufficient information for staff to refer to about the person's overall pain-relief strategy.
• When people had known allergies and sensitivities to medicines records were sometimes inconsistent which could have led to error and medicines being administered inappropriately.
• When people were prescribed medicated skin patches there were additional records to ensure they were applied appropriately and removed but these were not always being completed by staff.
• There were audits and checks of medicines in place but incidents and errors relating to medicines were not being raised so that appropriate improvement actions could be taken.
• Medicines were stored securely, however, temperature records were not always being completed for medicines requiring refrigeration to ensure they were being stored within the appropriate temperature range and therefore safe for use.
• Windows were found without restrictors in place putting people at risk of falls from height. This had previously been identified by the commissioning body for the service however no action had been taken in response.
• Exposed hot pipes were found in the home. This put people at risk of burns or scalds if a fall occurred in these areas. This risk had also been previously identified by the commissioning body.
• An area of flooring had been identified as very hot to the touch resulting in a burn mark to the floor covering. This had been raised by the regional manager, to the provider's estates team, on 10 April 2019. However, the risk was still evident during our inspection visit on 1 May 2019. No consideration of the risk this posed, both in terms of people falling on this area or the potential fire risk, had been made.

• Accessible chemicals were found in two areas of the home with a third person's medicine cabinet, containing prescribed topical medicines, found to be unlocked and accessible. This posed a risk of accidental ingestion to those people living with dementia.
• Some people were observed not to have call bells so were unable to call for assistance.
• One person had experienced three falls since February 2019, however the risk had not been identified, managed or mitigated with no associated risk assessment in place.
• Another person had developed a pressure area when the equipment they had been assessed as requiring had not been in place when they were first admitted into the home.
• For a third person who had been diagnosed with a chest infection, the service had failed to ensure the person had received the antibiotics as prescribed. This person was later found unresponsive and staff failed to request appropriate and timely medical assistance putting the person at further risk.

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

Preventing and controlling infection; Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• People were at risk due to inadequate infection prevention and control measures being in place. Some people we spoke with told us of incidents where the service had failed to maintain cleanliness. One person told us, "It's not unusual to find wee and poo in my room and on my duvet." Another person told us about an incident where they found faeces in their room.
• Our observations during our inspection found areas of the home to be unclean. On several occasions we found faeces in toilets. What appeared to be faeces was found on a radiator cover in a person's bedroom. This was raised at the time it was found but was still present two days later when we next inspected. Faeces was also seen on a person's quilt.
• Moving and handling slings were shared by people without being cleaned or decontaminated between use.
• Offensive odours were present within the home. Carpets had been identified as not fit for use and although plans were in place to replace these, they continued to give off offensive odours.
• The service had failed to comply with the Department of Health's Code of Practice for health and social care on the prevention and control of infections. For example, during a two-week period, 11 people had either been diagnosed as having a chest infection or noted as having symptoms of such an infection. The risks associated with this had not been identified and mitigated by the service and they had not been referred to Public Health in order to safeguard people.
• On the first day of our inspection, only one hoist was available to move and transfer the eight people who required it on a routine basis. Furthermore, due to maintenance work being carried out on the passenger lift, the hoist was only accessible to those people on the ground floor of the home. Enough equipment to provide a service was not consistently available.
• Some staff who operated the hoist had not been appropriately trained to operate the equipment.
• The hoist that assisted people into the only working bath in the service was not in use and had failed in March 2019. This meant people did not have access to a bath.

The above concerns demonstrate a breach to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• The service had systems in place to safeguard people from the risk of abuse but these were not effective.
• During our inspection, we identified people who had not received basic care resulting in offensive body odour, dirty fingernails, poor oral hygiene and unkempt hair. Staff had failed to raise this as a safeguarding concern and we saw, from minutes of the staff meeting held on 26 March 2019, that they had been reminded

of their responsibilities in this area.
• Not all staff had received training in safeguarding adults.
• We identified an incident where a person's valuables had gone missing that had not been reported to the local authority safeguarding team as required.

The above concerns demonstrate a breach to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Potential staff had undergone some checks to ensure their suitability before starting in role. However, full employment history and explanations of any gaps had not been gathered for all staff files we checked. This is a requirement of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Of the four people we spoke with about staffing levels, three told us there were not enough staff to meet their needs. One person said, "There are too few carers for the number of people here" whilst another told us, "They are always short-staffed." A third person said, "Staff are very busy."
• All the care and ancillary staff we spoke with told us there were not enough staff to meet people's needs and complete their role as required.
• Our observations demonstrated that there were enough staff on shift at the time of our inspection to meet people's needs however there was a lack of organisation and direction that made them ineffective at meeting people's needs.
• The service used a dependency tool to assess required staffing levels according to people's needs. We checked these staffing levels against the rotas for the four weeks leading up to our inspection. We found that at least three shifts per week ran below the staffing levels the provider had assessed as being required.

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.

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

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The service had failed to adhere to the MCA and protect people who lacked capacity to make their own decisions. One person we spoke with told us, I feel a little bit restricted; I am not allowed to do a lot of things, it's a bit like being a child."
• For one person who lacked capacity and had an authorised DoLS in place, the service had failed to meet the associated conditions. This put this person as risk of receiving care and support that was not in their best interests.
• For another person, the service had applied for a DoLS without ascertaining their capacity to make their own decisions. Furthermore, staff had made a decision on their behalf without consulting anyone but themselves.This was not in line with guidance around making decisions in people's best interests.
• For a third person, the service had unauthorised restrictive practices in place including dictating how that person spent their day. Whilst this was to protect the individual from harm, the service had not gained appropriate authority to do so.
• Out of the 30 staff employed, almost half (14) had not received training in the MCA and DoLS.

The above concerns demonstrate a breach to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• People's nutritional needs were not met.
• The service did not ensure adequate time between meals. We saw that two people received their breakfast

at 11am and were then served their lunch shortly after 1pm. For one of these people, we saw that their breakfast was removed almost complete with a full cup of tea having been untouched.
• For one person, an inspector had to intervene several times to ensure they received a full lunch. When replacement food was finally served to them, no hot food remained and they were given sandwiches without being asked if the filling was of their choosing.
• We could not be assured that people received adequate hydration as records told us people received little fluid on some days. During our inspection, one person asked a member of the inspection team for assistance with a drink that had been placed out of their reach.
• We observed lunch being served on one day of our inspection. We saw that people did not have access to condiments, were not offered a choice of drink and had to wait between courses. This resulted in people getting up to leave before they had received their full lunch. One staff member was assisting two people at the same time and the experience was chaotic for people. There was no choice for those people who were vegetarians.

The above concerns demonstrate a breach to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Staff received most of their training online. However, only five of the 30 staff employed had up to date training in place in the subjects the provider deemed mandatory.
• For one person who lived with diabetes we saw that their care plan stated that staff knew the signs of poor diabetes management and knew what to do in the event. However, staff had not received training in diabetes and not all of them could tell us this information when we spoke with them.
• Staff told us they did not receive regular support or supervision and the records we viewed confirmed this.
• We saw an example of poor moving and handling technique during our inspection demonstrating that staff did not consistently have the skills required to safely support people. Only five staff had recently received an assessment of their competency in moving and handling.

The above concerns demonstrate a breach to Regulation 18 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; Staff working with other agencies to provide consistent, effective, timely care
• People's needs had been holistically assessed however the care they received was not delivered in line with legislation, standards and evidence-based guidance. For example, The National Institute for Health and Care Excellence's (NICE) guidance 'People's experience in adult social care settings: improving the experience of care and support for people using adult social care services'.
• Equipment was not consistently available to people who used the service to enhance their experience and promote their independence. For example, the service had only one hoist available to assist people and, for another person, we saw that their frame was removed discouraging their independence.
• For one person who was transferred to hospital, we saw that written transfer information was not made available to healthcare professionals to help ensure continuity of care.

Adapting service, design, decoration to meet people's needs
• Felmingham Old Rectory was a period building in a poor state of repair. During our inspection we saw a hole in the ceiling of a corridor, a water leak in the communal lounge and were told there was a problem with the drains in one bathroom. A scorch mark was evident to the flooring in one area.
• Due to the above issues, people had to move rooms causing confusion, particularly to those who lived with dementia. Some of the above issues had been identified by the provider for some time and had failed to be

rectified in a timely manner.
• There was some signage in place to help people orientate themselves around the home. However little identifying information was in place to help people recognise their room.
• Because one person was at the end of a long and winding corridor, they had little interaction with staff and saw little activity. They told us they felt lonely.

Supporting people to live healthier lives, access healthcare services and support
• People had received interventions from healthcare professionals however their recommendations had not always been followed. For example, one person had been under the care of the dietician where dietary recommendations had been made in their best interests to maintain their health and wellbeing. These recommendations had not been followed by the service putting the person at risk.
• For the same person we saw that there had been a delay in arranging for the person to see a healthcare professional following a recommendation made after a hospital appointment.

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.

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

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

• People were not consistently treated with kindness and compassion.

• One person who used the service told us, "Staff look after us okay I suppose, basic. The staff can be abrasive if you face up to them…" Another person said, "Staff are okay, they do their job, some of them are really just worn out. They are nice enough, occasionally they get shirty." A third person explained that staff 'sometimes' lost their patience with them.

• Our observations showed that staff varied in their approach to those that used the service. Whilst we saw some kind interactions, we also saw examples where staff were dismissive and uncaring. When one person was incontinent in a communal area, we saw a staff member interact with them with resignation and impatience.

• On another occasion, we saw a staff member enter a person's room, without gaining permission to enter, placed a drink on their table and said, "tea" before walking out. The staff member made no other conversation with the person.

• For a third person, we saw them in distress, calling out for help. We saw that a number of staff walked by this person without offering any support, comfort or interaction.

• People's dignity was not maintained.

• During our inspection we saw people unkempt with unclean clothes, hair and fingernails. Some people were seen to be dishevelled.

• Records did not demonstrate that people had received regular and consistent personal care. For example, for one person, who the service deemed not to have capacity, their records showed they had not received personal care for three days due to refusal. Records did not demonstrate that staff had made further attempts to assist this person with their personal care. We noted that the person had an offensive odour and was unkempt. The service had failed to maintain this person's dignity.

• We observed one female who used the service with long, visible and numerous facial hairs that compromised their dignity.

• People had not received regular oral care. One person's records showed they had received assistance with oral hygiene only three days out of the month of April. We viewed the daily notes for a second person over a seven-day period and these showed no oral care had been given over this time. A staff member told us only half of those people living in the home had access to toothpaste.

• We saw one staff member leave the door open after having assisted a person to shower. This left the person visible to communal areas in a state of undress.

• For an additional person, the service had switched off the water in their room meaning they had no access to water in their private space.

The above concerns demonstrate a breach to Regulation 10 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 had not been involved in the care and support they received. One person told us, "I don't feel involved in my care, no, I just do what I'm told."
• Care plans did not demonstrate that people, or their relatives, had been fully and consistently involved in the planning of the care and support they received. Consent for care was not consistently in place.
• The people who used the service had not been asked for their views on the service they received.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People received interventions that were task-driven with no consideration for their individual needs, health or wellbeing. Care plans were inconsistent in their contents and reviews were sporadic.
• One person who used the service told us, "Care is sufficient I suppose. I wouldn't say staff don't care, but they haven't got time to care. They are just doing a job." This person went on to say, "I'd rather be in prison." Another person, who had no call bell in their room, said, "If I needed help, I would call them by shouting," A third told us, "I don't really feel confident with the staff. I think if I was to ask them about dementia, they wouldn't know about it."
• Three of the staff we spoke with told us they had concerns about how people were cared for. One told us, "Service users don't get looked after the way they should. They miss meals and drinks." They went on to say, "No one here cares. I'd rather see this place closed down so service users get better care." When we asked a second staff member how they found the home, they replied, "Horrendous." A third staff member told us people did not receive basic personal care and that they had recently had to assist a person with a shower who had not received any personal care for four days.
• From the care plans we viewed and from our observations, we saw that people's basic needs were often not met and that they did not receive care that was personalised to them.
• One person had ulcerated legs and their care plan instructed that their legs were to be elevated and that they were to have daily bed rest to aid healing. We checked this person regularly throughout our first day of inspection and saw their legs were not elevated. Nor did they receive bed rest and we observed that their bed remained stripped and unmade throughout the entirety of our first inspection visit.
• Another person had fallen from bed and injured themselves after staff had failed to ensure equipment was in place as planned to mitigate the risk of harm should they fall.
• For a third person who was coming to the end of their life, we saw little person-centred information in their care plan; the recorded information that staff would use to assist this person was task-focused.
• Staff had little time to engage people in meaningful activities and those people that used the service told us they were bored with one telling us they felt lonely.
• One person said, "I don't do a lot all day, I sit around, sometimes we do stuff like painting or gardening, but we don't do that very often to be honest." Another person said, "I'm in bed because there is nothing to do." A third person explained, "I get bored. I see carers sometimes" with another stating, "There's nothing to do but sit around."
• Another person was keen to show us their room which was stark with little personalisation. They briefly engaged in conversation before picking up their magazine and leaving their room. When we asked if they were going to the lounge they said, "I don't have much choice do I?" They were resigned in their choice of activity.
• Our observations confirmed people were not stimulated or engaged. We saw people sitting around, sleeping and, for one person, constantly walking the corridors of the home as they had nothing to engage in.

Some activities were supplied but few people engaged in these and they had little meaning for people and their lives.

The above concerns demonstrate a breach to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• We saw little evidence of how the service responded and managed complaints.
• Only one recent complaint had been logged and we saw that this had been investigated and that the service had liaised with the complainant. However, appropriate action had not been taken regarding referrals to other stakeholders.

End of life care and support
• There was one person on end of life care at the time of our inspection.
• For this person we saw little person-centred detail in their care plans however we were told these were currently being updated. We later saw staff meeting with the person's family to ensure care plans were up to date.
• For other people whose care plans we viewed, we saw that no end of life wishes had been discussed or recorded.

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.

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

The service people received at Felmingham Old Rectory was poor and fell well below the expected standards. People did not consistently receive basic care and lived in an environment that was unclean, odorous and in need of repair. Their quality of life and dignity was compromised.

Continuous learning and improving care
• Adequate provider oversight to drive improvement was ineffective. Despite carrying out regular audits, including those completed by the regional manager, the standard of care people received was poor.
• The provider themselves had long identified shortfalls in the service however prompt action had not been taken to improve the care and service people received. For example, a group supervision took place with staff one year ago highlighting concerns around people not receiving personal care, their dignity not being maintained and poor record keeping, amongst others. These concerns remained at this inspection one year later.
• An entry in the staff communication book, dated 17 April 2019, instructed staff to ensure odours are cleaned, to document oral hygiene and robustly record what personal care people are receiving. This demonstrates that the provider had identified these issues as concerns.
• The home's action plan shows that a number of concerns highlighted at this inspection have been apparent for some months. For example, around staff skills and competency. The plan shows that staff training remained outstanding in September, November and December of last year and remained so to date. Lack of staff supervisions and appraisals was first highlighted in November 2018. Offensive odours had been identified by the provider in January 2019 and continued to be so. These remained at the time of this inspection.
• Unstable management had contributed to the poor quality of service people received and staff were demotivated and demoralised as a result and this had impacted on the service people received.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
• People lived in a home where the culture was poor. This was evident from what people told us and from our observations.
• Staff were demotivated and resigned to working in a service that did not provide adequate care. This was evident from what they told us and how they went about their role. For example, when we enquired with staff as to whether a person had received their lunch, instead of asking that person, they assumed the person had. They did no more to ascertain whether that person had received a meal or whether they were hungry.
• Staff did not feel supported, valued or listened to in their role. They told us they had not been involved in

decisions around the service. They had not been consulted and felt unempowered to make suggestions. Minutes from a staff meeting held on 26 March 2019 showed that staff had raised concerns that remained at our inspection.

• There were not enough resources in place to free up the senior management team to be on the floor as required to perform their roles. We saw that they were fire-fighting, particularly around the issues with the building which required their immediate attention. This had impacted on staff morale and support and did not allow for the management team to have a full understanding of the service people were receiving or to monitor staff performance.

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

• The service had not had a registered manager in the service since September 2018. The service was on their third interim manager and the regional manager had also recently changed, all contributing to instability within the service. As part of their registration, the provider is required to have a registered manager in the home.

• We observed the service at the home to be chaotic, particularly on our first inspection visit. There were a good number of staff on duty, some of which were agency staff, however they were ineffective and received little instruction or directions.

• Most staff had not received regular feedback on their performance and, where some had, they told us this was critical. One staff member told us they felt 'barked at' whilst another told us they were bitter towards the home as regional management were unable to adequately communicate with them.

• There had been no oversight or regard for care records and associated documents and some had been placed, in a chaotic manner, in a draw in the care office. This not only made it difficult for staff, and professionals, to access information but posed a risk to the confidentiality of people's personal data.

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

• Staff, people who used the service and others had not had regular opportunities to voice their views and opinions on the service and had not been involved in decisions.

• Regular meetings had not been held with people and no surveys or questionnaires had been offered to those that used the service, their relatives, staff or professionals.

Working in partnership with others

• The service had failed to fully act on concerns raised by other stakeholders exposing people to risk.

• The commissioning body had visited the service on 24 April 2019 and raised concerns about the safety of people. At the time of our inspection, those concerns had not been acted upon in full by the service.

• A food hygiene inspection by Environmental Health had been completed in February 2019 which resulted in a number of concerns being raised and actions required. This had resulted in a food hygiene rating of two out of five. A revisit was underway at the time of our inspection which found the service had not complied with all the actions required.

All of the above concerns demonstrate a breach to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had failed to ensure people who used the service received care and treatment that was appropriate, met their needs and reflected their preferences.

The enforcement action we took:

Notice of Proposal to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The people who used the service were not treated with dignity and respect at all times.

The enforcement action we took:

Urgent Notice of Decision to impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The people who used the service had not been treated with dignity and respect at all times.

The enforcement action we took:

Notice of Proposal to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment had been provided without consent of the relevant person in place.

The enforcement action we took:

Notice of Proposal to remove location.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, manage and do all that is reasonably practicable to mitigate the risks to the health and safety of service users of receiving care or treatment. Medicines management and administration was unsafe and failed to adhere to current legislation and guidance. The provider had failed to assess the risk of, and the prevention, detection and control of the spread of, infections, including those that are health care associated.

The enforcement action we took:

Urgent Notice of Decision to impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, manage and do all that is reasonably practicable to mitigate the risks to the health and safety of service users of receiving care or treatment. Medicines management and administration was unsafe and failed to adhere to current legislation and guidance. The provider had failed to assess the risk of, and the prevention, detection and control of the spread of, infections, including those that are health care associated.

The enforcement action we took:

Notice of Proposal to remove location.

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 Systems and processes had failed to protect people who used the service from abuse and improper treatment.

The enforcement action we took:

Notice of Proposal to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of the people who used the service had not been met.

The enforcement action we took:

Notice of Proposal to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe and unsuitable premises. Equipment used by the service provider had not been properly used was not appropriately located for the purpose for which it was being used. Standards of hygiene in relation to the premises and equipment was not being properly maintained for the purposes for which they were being used.

The enforcement action we took:

Urgent Notice of Decision to impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe and unsuitable premises. Equipment used by the service provider had not been properly used was not appropriately located for the purpose for which it was being used. Standards of hygiene in relation to the premises and equipment was not being properly maintained for the purposes for which they were being used.

The enforcement action we took:

Notice of Proposal to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective at assessing, monitoring and improving the quality and safety of the service and mitigating the risks associated with the health, safety and welfare of the people who used the service. The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of people who used the service. Feedback had not been sought from relevant persons and others for the purpose of continually evaluating and improving the service.

The enforcement action we took:

Urgent Notice of Decision to impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective at assessing, monitoring and improving the quality and safety of the service and mitigating the risks associated with the health, safety and welfare of the people who used the service. The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of people who used the service. Feedback had not been sought from relevant persons and others for the purpose of continually evaluating and improving the service.

The enforcement action we took:

Notice of proposal to remove location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy a sufficient number of suitably qualified, competent, skilled and experienced staff. Staff had not received appropriate support, training, professional development, supervision

and appraisal to enable them to carry out the duties they had been employed to perform.

The enforcement action we took:

Notice of Proposal to remove location.