Mr S Siventhiran

The Oaks Care Home

Inspection report

432 Birmingham Road
Marlbrook
Bromsgrove
Worcestershire
B61 0HL

Tel: 01527876450

Date of inspection visit:
16 July 2019
17 July 2019

Date of publication:
15 October 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
The Oaks Care Home is service that provides accommodation, nursing and personal care for up to 16 people. At the time of our inspection, 13 older people were living in the home, some of whom may have a physical disability and/or dementia.

The Oaks Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is in one adapted building over two floors.

Why we inspected
This was a scheduled inspection. We had also received concerns from members of the public regarding staffing levels and the environment which we took into account.

People's experience of using this service and what we found
People did not feel safe from abuse. Staff did not recognise different types of abuse or how to report it. The registered manager and provider did not recognise abuse and how to report this. We raised safeguarding concerns to the local authority from what people had told us and records of incidents we had read. Risks to people's safety were not always monitored or reviewed. People told us that their care needs were not met in a timely way. People's medicines were not always managed and stored in a safe way. People were not protected from the risk of cross infection.

People's care was not always robustly assessed and reviewed to ensure it was up to date and in line with best practice. People were not supported by staff who had the skills and knowledge to do so. People who needed support to eat were malnutrition as records did not clearly demonstrate that people had sufficient to eat and drink. People were not supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff did not treat people in a kind and caring way and their dignity was not maintained. The staff group did not always treat people as individuals and respected the choices they made. People did not always receive care and support in a person- centred way.

People's care was not always delivered in a timely way, people experienced consistent delays in receiving personal care. The provider could not be assured the staff group had sufficient knowledge and skills to support people with their care needs including end of life care. People were not supported to maintain their hobbies and interests. Complaints were not fully addressed to ensure satisfactory outcomes were made.

There were significant and widespread shortfalls in the way the service was led. The provider and registered manager did not lead by example. People, relatives and staff were not involved in the running of the service, the provider did not have a good line of communication and was not transparent to those involved in the service. The audits the provider had in place were futile and did not escalate shortfalls to improve practice.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, 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.

Enforcement
We have identified breaches in relation to safe care and treatment and governance of the service at this inspection. 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.
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?

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.

The Oaks 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. 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.

Inspection team
On 16 July 2019 an inspector and an Expert by Experience visited the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 17, 22 and 23 July 2019 two inspectors completed the inspection.

Service and service type
The Oaks Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This was an unannounced inspection.

What we did before the inspection
Our inspection was informed by evidence we already held about the service. We had received information of concern about staffing levels and the environment. We also checked for feedback we received from members of the public and the local authority. 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. We used all of this information to plan our inspection.

During inspection
We spoke with four people who used the service and five relatives. We spoke with the six care staff, the chef, the deputy manager, the registered manager, the provider. We spoke with a representative from the care consultancy the provider had hired since 19 July 2019. We looked at aspects of five peoples care records, along with 11 people's medicine records, handover information, audits of records and complaints. We also spoke with a fire officer, safeguarding officers from the local authority, commissioner and quality leads from the local authority and a social worker.

After the inspection.
We shared out concerns with the safeguarding officer at the local authority and commissioner and quality leads from the local authority.

Inadequate

Is the service safe?

Our findings

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

At our last inspection in May 2018, this key question was rated "Requires Improvement" at this inspection we found the rating had deteriorated to "Inadequate". This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The provider's systems and processes failed to keep people safe from abuse. People told us they were not always supported to have their continence care needs met. One person told us how they were told off by staff when they required support with their continence needs, with threats made to inform relatives of their 'wrong doings'. A further person said, "You have to shout and hope someone comes, but if they [staff] are out in the garden having coffee and a fag they don't hear you." They continued to tell us how they had been left like this for an hour. A relative told us they would often find their family member without their continence needs met and would support them with this themselves.
- Over the first two days of the inspection, we saw staff sat in the garden with no staff in the communal areas. We heard people calling for help and their requests not being answered. The inspection team had to intervene and seek staff, so that support could be offered to people.
- One person had formally complained twice to the provider about staff neglecting their care needs, however, the provider had failed to take action to address this, or escalated as a safeguarding concern. The person told us that staff continued to neglect their care needs.
- The lack of supervision had put people at risk of harm. For example, we had read of serious incidents that happened between people living in the home, and found people had been subjected to abuse which was not mitigated by the staff group. People had food, drinks and walking aids thrown at them, with it being reported that one person was stabbed by a folk. However, actions to protect people had not been taken. We saw people continued to be placed at risk of harm as they were not supervised in the communal area. We saw one person was surrounded by old food and drink that was on the walls where they usually sat, which had been previously thrown at them, and they sat in items of their clothing which staff had not supported them to change from.
- Staff told us there was a 'fag culture'. Where those who smoked would be out in the garden for up to an hour first thing in the morning, leaving people waiting for their care needs to be met. Staff told us that this was encourage by the registered manager.However, staff had not alerted outside agencies of their concerns that people's needs were being neglected and the potential risks.
- Staff we spoke with did not have sound safeguarding knowledge. Where we gave a scenario of verbal abuse towards a person living in the home, staff said they would ask the person what they had done to upset the staff member, and then wait to see if it happened again before they reported it. Some staff were obstructive to the inspection and questioned our right to ask about people's safety and were reluctant to respond to our questions.
- We reported these safeguarding concerns to the local authority so that action could be taken to protect people from potential future abuse. We informed the provider of the allegations that had been made to us, however they failed to immediately reduce the risk, and only acted two days later following CQC procedures.

● Staff, the registered manager and provider did not recognise different types of abuse in order for them to adequately protect people. There was a blame culture within the service, which stemmed from the provider, it was more important to find out who raised the concern, rather than mitigating the risk of future incidents. Reportable incidents were not shared with the CQC or the Local Authority, to demonstrate people were being kept safe and having their needs met.

The above information is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People were at risk of harm in the event of a fire. There were no risk assessments or plans in place to inform staff about what action should be taken to keep people safe in the event of a fire. Staff told us that fire drills did not happen and were unsure what actions they would take to keep people safe. The provider was unable to demonstrate how they performed a fire drill to show us how they knew their staff had the skills and knowledge. We found the laundry in the basement posed a fire risk. The fire door was propped open and there were large amounts of laundry alongside combustible items such as papers, boxes and chemical solutions. We reported our concerns to the Fire and Rescue service who made checks to ensure the building and the people living there were safe. They visited on 23 July 2019 when we were there and put plans in place to mitigate risk.

● People were put at unnecessary risk of harm as staff had not been sufficiently trained and assessed as competent to use safe moving and handling procedures. One person who required a hoist to be moved safely from their bed to a chair told us, "Staff use other means to move me," and confirmed this was not through the use of equipment. We saw a further person who required a hoist with two staff, was seen being supported in their wheelchair from their room with only one staff member. The registered manager could not confirm that competency checks took place to ensure staff understood the importance of following safe moving and handling procedures.

● People were put at unnecessary risk of harm as plans to reduce risk were not implemented. For example, were one person was at risk of leaving the home, one of the measures was for one to one staffing support. Over the first two days of our inspection this did not take place and we saw the person was unsupported which posed a risk to themselves and others.

● There was a failure to have any oversight of people's care needs. For example, it was not clear who was at risk of losing weight, who had sore skin, who was at risk of dehydration, or who was at risk of falls. Without an overview of people's risks and how these were being managed the provider could not be assured staff were identifying and taking action to meet people's needs and keep them safe from harm.

Using medicines safely

● People were mostly receiving their medicines when they should. We found on some occasions people had not been given their medicine and the reasons recorded were not clear. One staff member told us they would not give their medicine if the person was asleep. From the records we saw staff had not attempted to offer the medicine later and just destroyed the medicine. It could not be evidenced that staff had made checks with the person's doctor to understand if it was safe that people were missing their medicine.

● We also identified concerns regarding the storage of medicines. We found that when medicines had been opened, they were not dated, to ensure the medicine was being used within its expiry date. We also found a paraffin-based cream in a person's bedrooms, there were no directions for staff for the safe use of this flammable product, such as care if smoking, or ensuring the clothes that the cream would have soaked into was washed at a higher temperature to reduce the risk of fire when being tumble dried.

● People's prescribed creams did not have documentation in place to accurately record where, how and when it was applied. The provider could not be assured staff were applying the prescribed creams as

required.

Staffing

● We had been made aware prior to our inspection of concerns about safe staffing levels, particularly at weekends and at night. One person told us they did not feel safe at night, as they felt alone. A relative we spoke with said, "There's rarely more than two staff on. Last Friday, there was only the manager and one member of staff to do everything." They continued to say, "As a general rule there isn't any staff in the lounge unless they are doing medications."

● We had read of incidents were people had unwitnessed falls, staff felt people were at risk of falling, or being left on the floor for long periods of time before they found them.

● Staff we spoke with felt there were not enough to meet people's needs and attend to the other tasks. For example, on the weekend, there would be only two care staff in the building. They were required to support people with their morning routine, prepare and cook breakfast, lunch and supper, support people to eat their food, assist to the toilet, as well as do medication, laundry and cleaning. We saw that when a person had left the building twice without staff's knowledge, this had happened on the weekend, when staffing was reduced even further. Staff also felt it raised concerns with infection control, as they were cooking, helping people to eat, and supporting people with their continence needs.

● We saw that staff sickness was not managed. Staff and the registered manager said some staff were not always reliable and would not arrive for work. However, staff were not made accountable for their actions, and sickness levels were not addressed. Staff reported that additional staff were not sought when this happened.

● We raised our concerns with the provider about insufficient staffing levels, and the provider agreed for an additional staff member to support a person. However, when we arrived unannounced the following week, we could see that the provider had not maintained this agreed staffing level.

● The provider did not have a full understanding of people's individual support needs and the skill mix of their staff to ensure they had sufficiently skilled staff to keep people safe.

Preventing and controlling infection

● The environment of the home was poor which made it difficult for staff to keep clean and odour free.

● Staff reported that there was a sickness and diarrhoea outbreak in the home a few weeks before our inspection and that most people were ill as it was difficult to control the spread of infection. It could not be evidenced this was reported to outside agency to ensure all actions had been taken. Further to this we found a specimen sample had been stored in the medicines fridge which was in the kitchen.

● Malodours were very strong within the home, which the provider only attempted to mask with air-fresheners, rather than ensuring the home was clean and well-maintained. A relative told us, "I don't touch anything when I am here. No wonder they get bugs."

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

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 "Requires Improvement". At this inspection we found this had deteriorated to "Inadequate". This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People we spoke with thought staff did not have the training and knowledge to meet their needs. One person said, "I don't think staff are trained or know what they are doing. They find it difficult as well."
- Relatives gave us mixed views about the way their family members were cared for and told us they were not always confident staff consistently met their family members basic care needs.
- Our inspection in 2017, identified staff did not have sufficient training. At the last inspection in 2018, staff told us they were completing the mandatory training required. At this inspection we found that staff had still not completed the training and staff lacked knowledge about many aspects of health and social care to enable them to support people effectively. This ranged from first aid skills, infection control, safe moving and handling, through to further training around dementia care, managing behaviour that challenges and catheter care. This directly impacted on the care people received, as with no understanding in recognising risk and how to respond to that left people vulnerable. For example, staff did not know how to manage behaviour that challenged, and continually exposed people to continued risk of harm. Staff had not had catheter care training and did not recognise the importance of monitoring fluid input and output to ensure the person remained well. We saw many times the person had been admitted into hospital because of significant concerns with their catheter because staff did not understand what was happening. The lack of knowledge and skills within the staff group had meant people had been exposed to significant risk of harm.
- Staff told us that spot checks and competency assessments were not carried out to ensure they were applying their skills and knowledge in the right way. We found that the provider and registered manager did not maintain their training to adequately assess staff's competency levels.
- The provider told us they arranged training, but staff did not attend, while staff told us that training did not happen. Regardless of this, the provider had not ensured their staff were trained and assessed as competent to deliver care and support in line with peoples' needs. The provider could not demonstrate that where staff had not completed their mandatory training, they had taken action against staff in-line with their policy and procedures.

This is a breach of Regulation 18 [Staffing] 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 told us they did not always have enough choice of foods or snacks to eat. One person said, "I've bought myself a malt loaf and some butter so that I can have a snack at night while I'm watching the TV." While a further person said, "Sometimes I'm very hungry, but I wouldn't dare tell them." They told us that the

previous evening people were only offered ham sandwiches for tea, with no other choices or options.
● Staff had not considered people's dietary requirements, and where people had specific dietary needs due to health conditions, these were not considered so that a suitable diet could be offered.
● We saw and staff told us that one person did not eat food that required chewing and would only eat softer foods. We saw from the person records that had lost weight 3kg of weight in three months, but staff had not explored the option that the person may now require a completely soft diet, so they had the nutrients they required.
● No assessments had been carried out to identify who may be at risk of dehydration. We saw there were people living in the home who may not be able to ask staff for a drink or recognise when they were thirsty. Staff did record what people had drunk, but this was not checked to ensure people had received sufficient fluids throughout the day. This lack of recording and monitoring could put people at risk of dehydration. We saw people were often being treated for urine infections.
● Staff monitored people's weight monthly, but it was unclear as to whether staff reviewed this over a period of time to be assured people's weight was stable and that any unexpected changes were being actioned. The chef told us they had not been made aware of those who were losing weight.
● People were put at unnecessary risk of harm as all staff who worked in the home had not received training about eating and drinking, which would encompass specialised diets and modified textured diets, so that they could recognise risks and escalate these to external healthcare professionals.

This is a breach of Regulation 14 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; Supporting people to live healthier lives, access healthcare services and support
● We found the initial assessments of people's care continued to not be in place since the last inspection in 2018. Relatives told us about people's risks that they had prior to moving into the home, such as falls or attempts of absconding from a home. These initial assessments of people's care were not held in the care records to reflect that the known risks had been assessed and actions put into place to meet the person's needs.
● Staff continued to support people to attend health appointments, opticians and dental appointments, so they would remain well. The GP visited weekly, and people told us they could also see their GP if they became unwell.

Adapting service, design, decoration to meet people's needs
● The Oaks Care Home is an older building which had not been adapted to always meet people's needs. A person explained that they were unable to use the two toilets on the ground floor, as the staff could not get the hoist in there to transfer them safely. While they had a commode in their bedroom, they said this was not suitable for use at all times. People, relatives and staff said that the toilet next to the dining room was too small to enable a staff member to support a person in there at the same time. One relative said, "The toilet in the corridor. You can't shut the door properly when someone is in it. You can see people in there. There's no privacy at all. It should be a broom cupboard."
● The provider had adapted one bathroom into a shower room. However, people told us they did not like this, as it simply a tiled room with a shower head into the room. Staff reported that people did not like that there was no defined shower space for them to protect their dignity.
● The corridor on the ground floor was very narrow and people reported knocking their arms on the radiator cover when being pulled backwards in the wheelchair. People told us, and we saw that those who used a wheelchair had to be taken backward and then down a step to get to the communal areas. We heard one

person scream out in pain when staff wheeled them down the step.

The above information is a breach of Regulation 10 and 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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.

● At the last inspection the registered manager and staff were aware of how to support people who lacked capacity to make choices about their care, and where people were being deprive authorisations had been sought. However, at this inspection, this aspect was not managed appropriately.
● We could see that mental capacity assessments had taken place, but where they had deemed they were depriving people of the liberty these authorisations and any conditions within them there were only expired authorisations on file. The registered manager was not able to tell us who had an up-to date authorisation or demonstrate how this was being shared with staff. They had no overview of authorisations, when they were expiring so that their needs could be re-assessed.
● We spoke with the local authority, about one person, who confirmed that they did have an in- date authorisation. While the registered manager had done this, without knowing the details and sharing it with staff, the provider could not be assured that they were working within the principles of the MCA.

The above information is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 our last inspection this key question was rated "Requires Improvement". At this inspection we found the rating had deteriorated to "Inadequate". This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- People shared examples with us where they were not treated or supported well, and as a result of this we raised safeguarding concerns to the Local Authority. People also told us, "You get them [staff] who can't do enough for you. But one in particular [staff name], the way they talk to you. I don't like [staff name]. They don't seem happy to help." While a further person said, "They don't take any notice. Unless you say you want a cup of tea, they don't bother."
- A relative told us, "I've heard staff raising their voices – saying 'calm down' – if they are trying to deal with aggression. They seem to make it a joke sometimes."
- Staff made unkind comments about people. For example, one staff member said to a person who had finished eating, "Have you eaten that or bathed in it, it's all over you." We saw care records which did not reflect a caring approach, about how staff had supported the person. We saw from records that staff had reported a period of time where they restricted a person from going into their bedroom during the day by locking the door.
- We spent time in the communal areas of the home and saw people were not supported with not only their physical needs but their emotional needs. Over the first two days of our inspection we heard people calling out for help with staff, and the provider not responding or acknowledging, when people cried for help. We had to ask the provider if they were going to respond to a person's cries for help. They replied, "They always call out." They did not recognise the person, who lived with dementia, required emotional support and re-assurance. This was explained to the provider, who then asked a staff member to help. The staff member said, "No, I am doing care plans," and walked away. The provider did not question the staff's unkind approach.
- What the inspection team saw and heard over the first two days of inspection raised serious concerns about the culture of the staff group. We could not be assured that people were well treated and supported, if this was staff's approach while an inspection was underway. We continued to share our serious concerns with the local authority and considered our own regulatory action that would be required.
- Following our concerns, the provider hired an external care consultancy to support the home. This was so they could monitor and identify concerns and then lead by example to bring change to the culture within the home. The following two days of inspection, we did see staff begin to support people with their emotional needs and physical needs when the consultancy service was here. A representative of the consultancy advised that it would take considerable time to improve the culture.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● People's privacy, dignity and confidentiality were not respected
● Staff's morale was very low, they expressed their frustrations with the management of the service and said they did not lead by example or provide a supportive environment to work in. We saw this was having a direct impact for people and the care and support they received. For example, two people told us they wanted to watch television in their bedrooms, but the building did not have TV points to do this. When they had asked the provider, their response was that they were not entitled to a TV in their room, and if they wanted this they would have to pay to put TV points in themselves.
● People told us they were not allowed to make outing calls to their relatives and were only allowed to have incoming calls. The provider said that people could receive calls in the dining room or office, however had not recognised that not only did this not maintain people's privacy, but also it was degrading to not allow people this freedom of choice.
● People told us they were not always treated in a dignified and respectful way and had been left with the continence needs not met.
● Relative told us that their family members clothes always went missing. One relative said, "We find dirty clothes in the wardrobe. We see [person's name] wearing other people's clothes. And other people wearing [person's name] clothes. Every day we have to fetch clothes from the laundry, as there are none in the wardrobe." We saw the laundry was dis-organised with laundry piled high, with no clear system to ensure people's personal possessions were respected.
● People's care plans which contained personal information were left unattended in communal areas of the home, we often found the office unlocked so anyone could access them. This did not respect people's right to dignity and confidentiality.

The above information is a breach of Regulation 10 and 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 "Requires Improvement". At this inspection we found the rating had 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

- Staff had limited guidance and directions in how to meet people's individual needs. Clear communication about people's needs and preferences were not always in place to ensure a holistic approach was provided to people.
- Staff were not always kept up to date with people's changing needs. Staff reported that they only received information from the shift directly preceding theirs and missed information about incidents and accidents that may have happened, unless they searched through previous handovers. Therefore, could not be sure they were providing the care people required.
- People were not supported with activities that were stimulating or meeting their individual needs. Most people spent their time in armchairs with the television on, but not watched. People repeatedly told us they were bored and did not know what to do
- Staff did not recognise that more could be done for people in terms of improving their social experience. Each day was the same, with no events to look forward to and no outings planned. The garden was in a poor state, and people told us it was never cared for. People did not enjoy going out into the garden, as staff smoked there, and there was no shelter from the sun.
- The registered manager and provider had not addressed the lack of stimulation. The provider said, "Last year we had a tea party which people liked". However, did not recognise that this was by no means sufficient to meet people's social care needs.
- Care staff continued to tell us that there were insufficient staff on duty to meet their needs. We saw that some staff were task focused, however we saw most staff were sat either in the garden talking amongst themselves.

End of life care and support

- The provider could not be assured staff had the knowledge and skills to meet people's end of life care needs. Where a person needed end of life care and support, the were no clear direction and plans for staff to follow. We heard the person cry out in pain, and staff reported that they complained of pain during personal care or moving them but did not recognise that pain relief maybe required to ensure the person was comfortable.

The above information is a breach of Regulation 9 and 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People and relatives we spoke with raised complaints to the provider about aspects of care, and the

environment. They said that these complaints were responded to, but not listened to. The provider continued to have the same complaints raised to them but did not take sufficient action to address these. Where some complaints met a safeguarding threshold, the provider had not escalated and mitigated the risk.

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.

● It could not be evidenced that people's communication and information needs had been assessed. There was not a range of communication tools and aids used to support effective communication with individuals and ensure they had information in a way they could understand.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection this key question was rated "Requires Improvement". At this inspection the rating had 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- One person said, "[The provider] is not very nice. [Provider's name] knows how to get you worked up." While another person said, "[Registered Manager] is alright, but only alright. I've talked to the owner and you don't get any sense out of them."
- A relative said, "The building is dire. [The provider] doesn't want to spend his money. He shouldn't be running a care home." With a further relative saying, "I haven't really seen [the provider] except when he is sat in the dining room. He doesn't really interact. It needs managing differently."
- Staff continued to express their frustration at the provider's lack of investment into the home. One staff member said, "The building is falling down around us, he makes promises, but nothing happens."
- Staff lacked clear direction and support and not all staff understood their roles and responsibilities. Staff told us that the management were poor, that they did not lead by example. One staff member said, "We need discipline, we need someone who is going to tell us what we are doing wrong. We need someone who will make us accountable for our actions."
- Staff morale was extremely low, the provider had not recognised this and said that staff morale was good. The provider had not engaged with staff, held meetings and kept them up to date with what was happening in the service. Staff reported that the provider and registered manager shouted at them and threatened them, but never praised them for the hours they did work. Staff were heavily relied upon to cover additional shifts and work additional long hours, without the praise or thanks, or view that this was a short-term measure until more staff had been recruited and trained.
- The provider had put some audits and checks in place; however, these were futile. For example, the checks for each person's care files, simply stated, "All records are fine". It could not be evidenced that these had been properly reviewed by a person who had the knowledge and skills to understand what they were reviewing to ensure the care needs were being met. Where they had reviewed incident and accidents, these were not robust, as while they were aware of serious incidents happening in the home, they had recorded that no incidents had occurred. Where they had recorded incidents had taken place, this did not look for patterns or trends to ensure learning was taking place.
- The provider did not seek feedback from people, relatives, staff or visiting healthcare professionals to understand whether they were satisfied with the service, and what actions you could take to improve the service. Where people and relatives did raise suggestions, these were not followed through.
- In February 2018, the provider sent the CQC an environmental improvement plan and confirmed action would be completed by February 2019. On inspection, the environment had not improved but further deteriorated. The provider presented to us a new five-year plan to improve the environment. The provider

continued not to recognise that five years to paint walls and replace flooring was not an acceptable period of time for people to live in poor conditions.

● The provider could not demonstrate that the running and maintenance of the home was proactive. The provider could only evidence works being completed after some time had broken.

The above information is a breach of Regulation 17 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 People did not receive personalised care and support

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not supported by trained and competent staff to safely meet their care and support needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not have their nutritional needs met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not adequate to support people with health and social care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have the training, skills and competency checks in place to deliver safe care. The registered manager and provider also lacked these skills and competencies.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse.

The enforcement action we took:

We imposed conditions on the providers registration to manage safeguarding allegations and to restrict admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a sound knowledge of health and social care in order for them to create a safe environment with staff who were trained and skilled to do so. Their continual lack of governance systems that were effective remained inadequate.

The enforcement action we took:

Cancellation of registration.