Raveedha Care Limited

Eastcotts Care Home with Nursing

Inspection report

Eastcotts Farm Cottage
Calford Green, Kedington
Haverhill
Suffolk
CB9 7UN

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Eastcotts Care Home with Nursing provides accommodation, nursing and personal care for up to 59 older people. There were 47 people living in the home when we visited on 3 April 2019. The home is situated in a rural area on the periphery of the village of Calford Green, Haverhill in Suffolk. We have referred to the home as Eastcotts Care Home within this report.

People's experience of using this service:

● The culture in which people were living required significant improvement; there was institutional and unsafe practices, which went unnoticed and unchallenged by senior staff.

● People were not supported by staff who were sufficiently skilled in their roles. The provider also failed to ensure that people were supported by staff who were all of good character.

● People were not always cared for by staff who promoted their rights to be treated with dignity and respect.

● Interaction between some care staff and people was poor and disrespectful. There were times when people's privacy and dignity were compromised. There was little social stimulation provided to people on occasions.

● People's personal records were not always stored securely to protect their privacy.

● The service was not acting in line with the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. This meant that people were at risk of having their liberty unlawfully restricted and inappropriate decisions could be made on a person's behalf if they lacked capacity to make the decision for themselves.

● The provider's quality assurance systems were not effective in identifying, responding and maintaining a good standard of service.

● People had a choice of meals and regular drinks were available. People were happy with the food they were served.

Rating at last inspection: The service was rated 'Requires Improvement' at our last inspection on 24 and 29 January 2018. The report following that inspection was published on 11 April 2018.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: 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 six months to check for significant improvements.

● The service met the characteristics of 'Inadequate' in all five key questions of safe, effective, caring, responsive and well-led

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

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority. The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC.

● Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

● If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

● 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.

● 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.

● 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.

Eastcotts Care Home with Nursing

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: This inspection was carried out by two inspectors, an assistant inspector, a specialist advisor with a background in nursing and dementia care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Eastcotts Care Home with Nursing is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no manager registered with the Care Quality Commission at the time of our inspection visit. The previous registered manager had left the service in September 2018. The service was currently being run by a manager who was there two days per week.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection we reviewed the information, we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). This is information that we request that asks the provider to give some key information about the service, what the service does well and any further developments they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we spoke with 15 people who used the service and ten people's relatives. We spoke with six care staff as well as two kitchen assistants, a housekeeper, two administrators, the deputy manager and the provider. We also spoke with a visiting healthcare professional. We reviewed a number of records including seven people's care records, medicines records and records related to the management of the service. Details are in the key questions below.

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 comprehensive inspection in January 2018 we rated this key question 'Good. At this inspection we found that the quality of care provided had deteriorated significantly. As a result, we have rated this key question 'Inadequate'.

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

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from avoidable harm or abuse because some practice in the home by some staff was abusive.
- We observed two people living with advanced dementia being helped with their lunch time meal and drink by a member of staff. The way the person was being helped and the force that was being used concerned us. The same member of staff also used a cleaning cloth that had been used to wipe a table to clean two people's faces. We were very concerned at these actions and asked the provider to take immediate action to address this. We also informed the local authority safeguarding team of our concerns and what we had observed immediately following our inspection visit.
- In another area of the service, we saw a person was regularly being shouted at and verbally abused by other people living in the home. This was because the pressure mat they were sitting on, that was in use to alert staff when they moved, was alarming every time the person sat forward in their chair and when they attempted to stand up. This occurred very frequently. The resulting sound was a loud beeping which caused other people a lot of distress and agitation. A visiting relative told us this had been the case for about two weeks and they had noticed during their visit increased anxiety amongst people as a result.
- Staff were not always present when this happened but when they were, they did not take any steps to prevent this verbal abuse from continuing to happen such as engaging people in an activity or distracting them. We saw the person trying continually to stand was persistently told, often very sternly and harshly, by some staff to, "Sit down" or "Sit". At times some staff also used physical intervention by placing some pressure to the persons shoulder or arm to make them sit down.
- People were not protected from the risks of abuse because senior staff failed to identify safeguarding concerns and take appropriate action. Systems were not embedded to identify or report concerns to the local authority adult safeguarding team and to CQC.

The evidence above demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Due to our serious concerns we wrote to the provider straight after our inspection visit to ask what immediate actions they were taking to address the concerns we raised. We also informed the local authority safeguarding team of our concerns about the actions of some staff and what we had observed during our inspection visit.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

● People were at risk of harm as the provider and staff did not have up-to-date detailed assessments of potential risks to people and how these were to be mitigated to keep them safe.

● One person had a significant mental health support need identified through an assessment when they moved into the service. Since admission no care plan or risk assessments had been put in place to guide staff of the risks of the person's mental health need escalating and monitoring needed in the event of a deterioration. This put the person at risk of life limiting consequences should their mental health needs escalate.

● As there was no up to date risk assessment or care plan staff were not aware of this significant risk. We were told during our inspection visit that the person was experiencing a deterioration of their mental health which made the lack of a risk assessment or care plan and lack of intervention even more concerning.

● Another person had an infection for which there was no care plan or risk assessment in place. Therefore, the risks associated with the infection had not been mitigated and there was no guidance for staff to follow when caring for the person to reduce the risk of the infection spreading to other people.

● Another person's care record stated that they were at high risk of falls and to reduce this risk, staff were to encourage them to use their walking frame. However, whenever they sat in the lounge staff removed their walking frame from their reach and placed it in a stacked-up pile with other people's walking frames that had also been removed from their reach. A member of staff told us, "We remove the walking frame so [person] doesn't try and stand up from their chair and fall when staff are not around." However, we saw on multiple occasions the person stand and try and walk from their chair holding on to furniture when there were no staff available and their mobility aid had been removed.

● If people in their rooms were unable to use a call bell due to their disability or cognition this was not always recorded in care plans to ensure that staff checked on the person regularly to ensure their safety.

● The carpet in the hallway of one of the units was in a poor condition. It had tape securing it; areas of carpet were missing with exposed concrete underneath. This was a trip hazard as well as being aesthetically unpleasing. We were told at this inspection that this carpet was due to be replaced imminently, however, we had also been assured that following our last inspection the carpet had been replaced. This had not happened and the carpet was still in place a year later.

The evidence above demonstrated that this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Due to our serious concerns we wrote to the provider straight after our inspection visit to ask what immediate actions they were taking to address the concerns we raised following which the missing care plans and risk assessments were put in place for staff to follow.

Staffing and recruitment

● People, their relatives and staff told us that staffing levels were not sufficient to provide the support that people needed. People told us that there were not enough staff to meet their needs in a timely manner and that they had to wait for their care. One person said, "There are just not enough staff about. You see one then they disappear and you don't see anyone again for a long time." Another person commented, "At night, staff can be cleaning rooms and doing laundry. I've 'buzzed' and been told I'll have to wait because they're in the laundry, I think they should be looking after us rather than being in the laundry."

● Some people's relatives were also concerned about the staffing levels. One relative told us, "Sometimes people in the lounge can be left alone when staff have to go and help people in their rooms."

● Staff told us they were concerned about the staffing levels and the impact that this was having on people's care. One member of staff said, "We do our best but need more carers". Another member of staff said, "Everyone [staff] digs in and we just get on with it but we need more staff."

● Our observations were that both the staffing levels and the deployment of staff was insufficient. Staff were extremely rushed and task focussed, we saw they had little time to spend with people. We saw frequent times during both days of our visit where people were left for long periods of time with no interaction. We also observed housekeeping staff frequently answering call bells and providing support to people, for example, with repositioning and eating and drinking when they had not received the appropriate training. This was because there was a lack of care staff available when that support was needed.
● The ethnicity of people working at the service was diverse. There were a high number of people who did not speak English as a first language and did not have sufficient grasp of the English language to enable them to perform the job role effectively. Some people, relatives and staff told us that this was of concern because basic communication with those staff was not possible. One person commented to us, "There's been a lot of staff who've left since the new manager came in and now they seem to be getting new staff] who don't speak much English." A relative told us, "There are insufficient numbers of staff at all times on the unit. A lot of the 'good staff' have left and most don't speak English, I can't understand them." Another relative said, "Staff don't speak good English. The ones that were good carers have all left and they have been replaced by non-English speaking staff and agency."
● Throughout the inspection visit there were numerous times when there were no staff available in communal areas within the home. One person was observed repeatedly trying to stand up during the day which triggered a pressure mat they were sitting on to alarm. The purpose being to alert staff the person was moving as they were at risk of falling. However, when the mat alarm sounded there were often no staff available to assist the person and when staff arrived the person was frequently told to 'sit' and 'sit down'. Some people were visibly upset at the noise level vented their frustrations towards the person. There were a lack of staff available to diffuse these situations.
Another two relatives we spoke with told us that in one of the lounges used by people living with advanced dementia, people were often left with no staff to support them.
● There was a lot of noise in the home, particularly from buzzers that were frequently sounding. A relative spoken with said, "The loud pitch of the buzzers is intrusive and disturbing to staff as well as to [people] and visitors." Another relative told us, "You can see the sound of the alarms habitually sounding is stressful to not only people who live here but also the staff."
● Recruitment of staff was not effective. Whilst pre-employment checks were completed, the provider recruited staff and commenced their employment without them having the necessary basic communication competency to meet people's needs.
● The deployment of staff needed improvement to ensure that people received care when it was needed. Our observations confirmed that there were insufficient staff and those staff available were not effectively deployed to meet people's needs in a timely manner or to keep them safe.

The above evidence shows a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to our serious concerns we wrote to the provider straight after our inspection visit to ask what immediate actions they were taking to address the concerns we raised. As a result, the provider told us staffing levels were being increased straight away, a staffing dependency tool to calculate the number of staff needed based on people's needs was being introduced. Also, staff without a good grasp of the English language were being removed from working at the service.

Preventing and controlling infection
● Apart from the carpet in the hallway in one area of the home, we found that the environment was generally clean. We saw housekeeping staff working throughout the home.
● Staff were provided with gloves and aprons to help prevent the spread of infection however we observed

some staff moving from housekeeping duties to assisting people without hand washing or changing of gloves and aprons. This practice placed people at the risk of infection.

Using medicines safely

● Peoples' medicines were managed safely. Medicines administration records indicated people received their medicines as prescribed.

● Staff completed training to administer medicines and their competency to do so was checked.

●Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

●Audits of medicines were completed to ensure policies and procedures were followed and any errors or concerns were identified.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At our last comprehensive inspection in January 2018 we rated this key question 'Good. At this inspection we found that the quality of care provided had deteriorated significantly. As a result, we have rated this key question 'Inadequate'.

Inadequate: Therewere 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 provider did not always ensure consent to care and treatment was in line with legislation and good practice. People's rights were not protected because staff did not always act in accordance with the Mental Capacity Act 2005 (MCA). The service had also sought consent from relatives who did not have the legal authority to agree to care and support on a person's behalf.
- MCA capacity assessments were not always taking place where particular decisions needed to be made and the person's capacity was in question. For example, one person who had been considered to lack the mental capacity to consent, had bed rails fitted on their bed. There was no evidence that a best interest meeting had taken place in relation to the use of bed rails. There was also no completed mental capacity assessment that related to the person's capacity or any evidence that any less restrictive options had been discussed. When we spoke with the person they told us clearly that bed rails had been applied to their bed without their consent and they did not want them there.
- Some people had alarm mats in place to alert staff if they were moving independently and were at risk of falling however, this was not evidenced as being part of a best interest's decision or where people had capacity, their consent to agree to this level of monitoring of them had not been obtained or agreed.
- We observed staff regularly removing mobility aids and placing tables in front of people's armchairs in an attempt to prevent the person standing up and moving. Staff we spoke with told us this practice was to keep people in their chairs to stop them falling. This was a form of restraint that had not been included in people's plan of care and where people lacked capacity, to consent to this practice, no best interest decision had been made to decide if this was the least restrictive option to keep people safe.

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

Staff support: induction, training, skills and experience

● The staff who cared for people did not always have the skills, experience or training they needed to deliver effective care. People could not be assured that all the staff would have the skills to meet their needs.

● We could not be confident staff always put their learning into practice. For example, we saw examples where staff did not follow good practice in supporting people to move safely.

● One member of staff was not confident or knowledgeable in using a piece of equipment to help a person stand and was intercepted by another member of staff who recognised they were about to use it incorrectly.

● Staff were unnecessarily 'hands on' with people and appeared inpatient as they hurried people whilst they were walking with a frame.

● We saw two staff move a person in their armchair to be sitting more upright in their chair. In order to do the care staff inappropriately lifted the person up in their chair by holding under the person's legs and arms. On another occasion we observed another person put their hands under the person's legs and dragged them to sit up.

● We found there were a number of staff who had insufficient English language skills to interact and communicate with people. This meant they struggled to speak with and understand service users and staff. Prior to them commencing work with people they had not been provided with any training in the English language in order to enable them to interact with people. This also impacted on their ability to read care plans, risk assessments and communicate with the emergency services should the need have arisen. One person told us, "Two or three staff can't even speak any English. It's hard enough for me to get by with them let alone someone who is living with dementia."

● A member of staff told us they were concerned about a number of other staff who could not speak any English. They told us that their lack of training and skills in this area impacted on care delivery telling us, "They do not understand what people want. This is frustrating and people do not get the care they need. One member of staff has to use an application on their phone to translate what is being said to them."

The above evidence shows a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to our serious concerns we wrote to the provider straight after our inspection visit to ask what immediate actions they were taking to address the concerns we raised. As a result, the provider told us staff without a good grasp of the English language were being removed from working at the service.

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

● We looked at how people's needs were reflected in the adaptation, design and decoration of the premises. Many people at the home were living with dementia and as such the provider had sought to make some areas of the environment dementia friendly with some reminiscence items available on the walls and in the lounge area, however this needed further development.

● Further improvements to the design and decoration were needed throughout the service to support people living with dementia. This was particularly relevant where people living with dementia were accommodated in what had previously been exclusively the nursing area of the home where best practice guidance for decorating areas to support people living with dementia had not been applied.

We recommend that the service finds out more about current best practice, in relation to the specialist environmental needs of people living with dementia.

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

● People's care was not provided in line with published guidance and best practice.

● Nursing staff carried out assessments of people's needs before they moved to the home. These included information about their care needs, such as their care needs, skin integrity and nutritional needs. However, these assessed needs were not always used to form care plans and risk assessments.

Supporting people to eat and drink enough to maintain a balanced diet

● We observed very poor practice when some people were being supported to eat and drink.

● People were complimentary about the food at Eastcotts Care Home. One person said, "The food is lovely; they get the portions just right for me." Another person told us, "The food is fine; you have a choice and you can ask for what you want."

● We observed lunchtime and the mealtime experience. Most people remained sitting in their armchairs in the lounges for lunch. There were limited spaces at dining tables available and not everyone would have been able to sit at one should they have wanted to.

● Care plans were in place in relation to people's nutritional needs and assessments such as the MUST (malnutrition universal screening tool) were used to determine if people were at risk nutritionally. People's preferences were included as part of their care documentation and for those people who required it, regular checks were undertaken of any weight loss. During our visit we saw kitchen assistants regularly offering people drinks between meals.

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

●People had access to health professionals in order to meet their health care needs.

●There was evidence staff contacted health professionals and supported people to attend hospital appointments. A visiting GP told us, "Staff can send me a message so if they have a problem as I'm local I can visit after surgery."

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 comprehensive inspection in January 2018 we rated this key question 'Good. At this inspection we found that the quality of care provided had deteriorated significantly. As a result, we have rated this key question 'Inadequate'.

Inadequate: 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 always well-supported, cared for or treated with dignity and respect. We observed occasions when some staff spoke with or treated people, in an abrupt or disrespectful way.
- We saw there were multiple missed opportunities for staff to engage and socialise with people who lived in the home. Many people and their relatives also said staff were too busy to have any meaningful engagement with them.
- Staff did not always treat people with kindness and did not uphold their dignity. Most care staff we spoke with confirmed that they did not have the time to offer people the care they wanted and needed due to the staffing levels.
- We saw some extremely poor interactions which lacked compassion and showed an uncaring attitude towards people from staff.
- A member of staff used a cloth to clean a table and then walked over to two people and used the same cloth to wipe their mouth. The member of staff did not explain what they were doing and approached the person from out of their sight line. The person was startled by the unexpected approach and screamed.
- When helping one person with a drink we heard a member of staff saying, 'drink, drink' in an abrupt and demanding manner. The person shouted, "No, go away leave me alone."
- We witnessed examples where staff did not behave in a caring or respectful way. For example, we saw one member of staff help people with their meal with none or extremely limited verbal communication where the staff member just said 'open' indicating the person was to open their mouth for their food.
- We saw another member of staff talking to people in an uncaring, curt and abrupt manner.
- When one person kept trying to stand from their chair the member of staff gave only the instruction, "sit" to them.
- We also observed some examples where staff did not respect people's privacy. We overheard staff talking about 'toileting' a person where others could hear them. We also heard staff making reference to the fact they were about to help a person with personal care by saying loudly across the lounge, "I'm just going to do [person]".
- People's personal information, such as their care records, were not always stored securely. This meant people's privacy was not always maintained. In the lounge on one of the units, staff frequently left people's daily notes on a table, folders open, when they were not in the room. This area was frequented by relatives

and visitors who would have had ample opportunity to pick up and view any records should they had wished to.
● Our observations confirmed that the lack of effective communication between staff and people was a barrier to effective and safe respectful care. Interactions from some staff towards people were non-existent at times, and often extremely abrupt.

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

● We informed the local authority safeguarding team of our concerns about the actions of some staff and what we had observed during inspection visit.
● We did observe some kind and caring practices, particularly from some of the kitchen assistants and the maintenance member of staff. They clearly had a good rapport with people and knew them well. The kitchen assistant working in the unit for people living with advanced dementia was observed responding to a person who asked for a yoghurt. This member of staff bent down to the person's level, made good eye contact and held the persons hand whilst smiling. They then proceeded to say, "Of course, what flavour yoghurt do you fancy, strawberry, toffee or banana darling?" The person held the member of staffs' hand in return and smiled.
● One person told us, "By and large I think they're good and some of the staff are really caring" Another person told us, "[Maintenance staff] is a lovely, lovely person and he's very good with those people living with dementia."

Supporting people to express their views and be involved in making decisions about their care
● People were not encouraged to make their own day to day decisions about their care, we found concerns relating to consent and decision making where people lacked capacity.

Inadequate

Is the service responsive?

Our findings

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

At our last comprehensive inspection in January 2018 we rated this key question 'Good. At this inspection we found that the quality of care provided had deteriorated significantly. As a result, we have rated this key question 'Inadequate'.

Inadequate: 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; End of life care and support

- People's needs were not always appropriately assessed or planned for and this risked impacting on their health and wellbeing. Some people's care plans contained contradictory information, had not been updated and lacked detail.
- Care plans were not always written collaboratively with people or their relatives, where appropriate.
- Care plans were not consistently linked to people's needs and did not always contain guidance for staff to follow for example, in relation to the support and management of a mental health condition or around any infections. This meant staff did not have sufficient information about people's needs to guide them in supporting people safely.
- We received mixed feedback about the opportunities for activities and for people to follow their interests and hobbies. There was a designated activity coordinator. This person was enthusiastic and had lots of ideas for activities and events, however they were one person trying to cover the whole home which in layout was quite sprawling.
- During our inspection visit the activities coordinator spent time with some people who remained in their bedrooms carrying out one to one activities such as reading. This was important for those people and enabled them to receive some valued interaction.
- However, whilst the one to one activities were taking place, other people within the home were not engaged. In one lounge where one of the inspection team spent most of the morning, the television was on with a news channel. The people in the room mostly slept in armchairs. During the latter part of the morning the activities coordinator came into the lounge, turned the television over to a music channel at which a couple of people woke up and began to engage with her. This was short lived. The activities co-ordinator went elsewhere with the home and many people returned to sleeping.
- There were missed opportunities by care staff to engage with people. When there was a member of staff in the lounge in the nursing unit, they often sat by the door completing care records. They had limited conversation with people and did not undertake any activity to promote involvement.
- One person was receiving end of life care during the inspection. We found very little information in the person's care plan to help staff deliver the person's care according to their personal preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notices were displayed which advertised a hairdresser attending the home. There were also notices about upcoming events being held at the home including; a monthly concert with a singer and one event advertised which included karaoke.
● During our inspection visit a church service was being held and several people attended.
● The activities co-ordinator was very busy during our inspection visit and we had limited opportunities to talk to them. We saw from posters they had created they had an enthusiasm for arranging trips and events for people to enjoy. One person told us, "[Activities co-ordinator] brings in dominoes and I look forward to her coming; we play dominoes and have a quiz." Another person told us, "We do crosswords and quizzes which I like." A person's relative commented, "I wish they had a few more trips, but they do look after [family member] and generally I'm happy with them here."

Improving care quality in response to complaints or concerns
● The provider had a complaints process in place and people were aware of how to raise their concerns. Although people we spoke told us they were able to raise concerns there were varying views as to the effectiveness of the management team in dealing with concerns raised. One person's relative told us, "I got on with the previous manager and would talk to her if there was a problem. I haven't seen much of the new manager, but would certainly raise an issue if I thought it necessary."

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 comprehensive inspection in January 2018 we rated this key question 'Requires Improvement' this was because we had not been informed of serious injuries that occurred at the service. At this inspection we found that the quality of care provided had deteriorated significantly. As a result, we have rated this key question 'Inadequate'.

Inadequate: 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.

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

- The governance of the service was not effective or robust and this was evidenced by the poor standards of care we found.
- At this inspection we found multiple breaches of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. Our findings indicated that people were not always safe or well cared for.
- The serious and extensive nature of the breaches of the Regulations we have identified demonstrate a failure of leadership and governance at the service at manager and provider level.
- There was no full-time manager at the service and hadn't been since the previous registered manager left in September 2018. The service was being managed by a manager two days a week. The provider told us he had been waiting for this person to commence full time at the service since September 2018 with no confirmation of when this may have been likely. The manager was not present during our inspection visit.
- Standards of care at the home had declined considerably since our last inspection. The provider was not aware of the majority of the concerns we raised during the inspection
- People and their relatives were not complimentary about the management arrangements or changes at the service. One person said, "[Previous registered manager] used to be here every day and was very approachable, but this manager only seems to come in twice a week." Another person said, "The old manager used to go around seeing people." A third person commented, "I'm not sure if I've met the manager."
- The provider, despite visiting the service twice weekly, did not complete quality audits during his visits to monitor standards of service provision.
- Poor practice such as moving and handling, and the lack of value given to people's dignity and respect had not been identified by senior staff
- We observed a safeguarding concern relating to the practice of a member of staff which we raised with the local authority following our inspection visit.
- There were a number of staff who did not have sufficient grasp of the English language to enable them to engage and interact with people. This had not been addressed as part of their recruitment into the home and they were permitted to commence work without the necessary skills. The provider told us during our

inspection visit that he was expecting us to raise concerns about these staff. Despite this, the staff were permitted to work in the service directly providing care to people whilst unable to communicate effectively or sufficiently with them.

● There was no effective process to determine staffing levels in the home which took into account the dependencies of people and the effective deployment of staff.

● Suitable arrangements were not in place to ensure people experienced person centred care. Staff were often task focussed and our inspection process found that people's choices and preferences were not always followed or respected.

● People's personal information, such as care records, was not stored securely. This meant people's privacy was not always maintained.

● The rating from the previous inspection report from the CQC was not displayed in a prominent place near the entrance of the home. The provider and administrator told us it had been but must have been removed. We reminded the provider that the rating of the home needed to be on display for people to see, as required by law.

● The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided. This placed people at unnecessary and avoidable risk of harm.

These concerns are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to our significant concerns we wrote to the provider after our inspection visit to request information about what action had been taken to address our most serious concerns. The response received demonstrated that some initial actions had been taken.

● Several staff we talked to spoke well of the manager. One member of staff told us, "Brilliant. If you have problems even outside of work you can chat to them."

● Some staff we spoke with told us that the staff team were supportive and worked collaboratively. One member of staff told us, "We all crack on and pull together". Another member of staff told us, "We are a hardworking team here."

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

● The service had previously had some systems in place to gather feedback about the service. These had included regular residents' and relatives' meetings and questionnaires. People and their relatives told us these meetings had not been held over recent months.

● Another person's relative said, "There haven't been any resident's meetings since [previous registered manager] left. I don't know why they have stopped and I haven't been told why."

Continuous learning and improving care

● There was no evidence to show how the provider assured themselves of what good dementia care was or how they kept themselves informed of current best practices.

Working in partnership with others

● The manager and staff worked with other professionals to ensure people received healthcare.

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 People did not receive personalised care in response to their needs.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always cared for by staff who respected their dignity and respected them.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in line with the MCA 2005 and the associated DoLS.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment were not always planned and managed in a way that promoted the health, safety and wellbeing of people.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment of staff was not sufficient to ensure that people's needs were met in a timely manner. Staff did not always have the necessary skills to meet people's needs.

The enforcement action we took:

We imposed conditions on the provider's registration.