Florence Care Homes Limited

The Oaks Residential Care Home

Inspection report

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31 August 2017
26 September 2017

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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

The Oaks is a residential care home that provides personal care for up to 30 older people, including people living with dementia. There were 24 people in the service when we inspected on 24 and 31 August 2017 and 23 people on 26 September 2017. This was an unannounced inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in June 2016 we found that the registered provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan to tell us how they intended to make the required improvements. At this inspection we checked whether these improvements had been made and found that the provider continued to be in breach of these regulations. Additional multiple breaches of the regulations were also found.

There was a lack of managerial oversight at all levels and leadership was not pro-active. The culture within the service did not promote a holistic approach to people's care to ensure that their physical, mental and emotional needs were being met. Robust and sustainable audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved. Quality assurance systems had failed to identify the issues we found during our inspection.

There was not an effective system in place to ensure there were sufficient numbers of staff on duty to support people and meet their needs. There were not enough staff to provide people with adequate supervision, nutritional support, stimulation and meaningful activity. This had a direct impact on people's safety and welfare.

People's care had not been co-ordinated or managed to ensure their specific needs were being met. Risks to people injuring themselves or others were not appropriately managed. People's medicines were not being managed effectively to protect them from the risks of not receiving prescribed medicines.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although most staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way. They did not always respond appropriately and in a timely manner to all of people's needs.

Care plans were incomplete, inconsistent and task led. They had not been updated to reflect people's current care needs. Opportunities to participate in activities were limited and activities provided were not personalised or tailored to meet people's level of ability, choice or preference.

Training for staff was not managed effectively. Training records did not accurately identify gaps in training and not all staff had received training in subject areas relevant to their role. Staff demonstrated an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) However, this wasn't always seen in practice. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Staff were aware of their responsibilities with regard to safeguarding people from abuse. However they were concerned that they would not be supported in raising concerns and that this could have negative repercussions for them.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection we took immediate enforcement action to restrict admissions and force improvement.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

There were insufficient numbers of staff deployed to meet people's care and support needs.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely.

Staff were reluctant to report issues and concerns which may constitute abuse.

Is the service effective?

Inadequate

The service was not effective.

Training and development was not sufficient in some areas to assist staff in the delivery of safe and effective care.

People were not always supported effectively with their nutritional needs.

The service did not always support people in line with the Mental Capacity Act.

Is the service caring?

Inadequate

The service was not caring.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

Although most staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way.

People were not always supported to be actively involved in making decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were incomplete, inconsistent and task led. They had not been effectively updated to reflect people's current care needs.

There was a lack of general activity throughout the day to ensure people's well-being.

It was unclear how the results of people's feedback was used to drive forward improvements.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight at all levels and leadership was not pro-active.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

There was not a positive culture which fully reflected the best interests of the people it served.

The Oaks Residential Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 24 and 31 August 2017 and was carried out by one inspector, a specialist advisor who had knowledge and experience in residential 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.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the provider, registered manager and nominated individual for the service. A nominated individual is a person employed by an organisation with responsibility for supervising the management of its regulated activity. We also spoke with nine other members of staff, including care and catering staff.

We spoke with nine people who used the service, seven relatives and two healthcare professionals. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care needs were being met we reviewed ten people's care records and other information, for example, their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2016 we found that people were not being protected against the risk of unsafe care, particularly in relation to insufficient staffing levels. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. At this inspection we found improvements had not been made.

There were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety. Despite being informed by the registered manager that a member of staff should always be present in the communal areas we observed there to be no supervision of people in the lounge and dining areas on several occasions throughout the day. We observed one person eating a paper napkin at the dining table when no staff were present and had to intervene and seek assistance in order to prevent the risk of the person choking. The lack of observation meant the person was at risk of serious harm as they were unable to assess the risk of their actions themselves. One member of staff told us, "We try to leave one carer in the main living room but it is not always possible due to the demands of the service." A health and social care professional who visits the service said, "It took me a while to find someone. I went back into the lounge, there was no carer in there."

At times people were not assisted out of bed until as late as lunchtime due to lack of staff. One staff member told us, "One day at lunchtime there were five breakfasts still sitting there because [people] had not been got up." Another member of staff said, "Yesterday we got the last person up at 12.15pm. It's not acceptable." A third member of staff commented, "Residents are often not up until 11.00 to 11.15 am." One person told us that they sometimes rang the telephone for the service using their mobile phone and asked, "Is anyone still alive in this building?"

People were not being assisted to use the toilet in a timely manner and were often left sitting in wet continence pads and clothing for long periods of time. One person told us, "They can take 15 to 30 minutes to respond to my call bell when I want to go to the toilet, sometimes I am aching before they arrive, sometimes I wet my pad." A member of staff said, "It's supposed to happen [assisting people to the toilet] before lunch but there is not time. They go in their pads. Most have dementia so they don't know. We have got a couple who we do change, the others are in wet pads until after lunch." Another staff member said, "When afternoon staff come in [people] are all soaking wet. It's degrading, not dignified. It's abuse."

Staff were struggling to meet people's basic health care needs. They were not deployed effectively to ensure that people were being provided with care and support in a consistent and planned way. This extended to all aspects of peoples health and welfare needs including a lack of social activity and mental stimulation. The activities co-ordinator employed by the service was unable to fulfil their role as they were needed to provide personal care. No social activity or time spent meaningfully engaging with people, other than when providing direct care and support, was seen throughout the inspection.

There was still no one employed specifically to carry out laundry duties, this was mostly the responsibility of the care workers. At our last inspection staff told us this element of their role took them away from spending

quality time with people. This continued to be the case despite the assurances given in the action plan submitted to us by the provider that a laundry assistant would be recruited.

The systems in place for determining staffing levels and shift planning were not effective to ensure sufficient numbers of staff to meet people's needs. A dependency level assessment tool was used to help calculate the numbers of staff required. However this did not take into consideration the additional responsibilities placed on staff such as the laundry or the fact that high numbers of agency staff did not know people and care may therefore take longer. A member of staff explained, "We have to work alongside the agency staff as they don't know codes to the doors nor the resident's needs in detail, even at handover it is not possible to explain to them the various residents individual needs & care." Another member of staff told us, "It's too much work for two few people. When you have staff who don't know the residents that slows everything down."

Staff were carrying out a variety of roles during one shift in an attempt to complete all of the required tasks. The registered manager had performed the role of either the cook or a senior carer in 9.5 out of 20 shifts they had recently worked. The housekeeping staff were expected to complete laundry tasks during the last hour of their shifts but care staff told us that this was not always possible so this task also fell to them. On the second day of our inspection the member of staff who was working as cook that day came to answer the door to us whilst also dealing with a phone call they had taken. They told us that they had come in early to administer people's medicines before starting the cooking. Later in the day they were seen to assist a person to walk from the lounge. This un-coordinated approach demonstrated that staff were unclear of their responsibilities. The senior staff were not seen to be leading and organising each shift which meant that staff were not where they needed to be in order to provide people with the care and support they needed and keep them safe.

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

Agency staff employed by the service had not been equipped with the knowledge they needed to safely and effectively meet people's needs. On the first day of our inspection three of the five care staff on duty were agency workers. One person with swallowing difficulties, who was prescribed thickener to be added to all fluids, was given an un-thickened drink by an agency worker. The senior carer on duty noticed a while later and intervened by taking the drink away. People with swallowing difficulties are at risk of choking or aspiration if they are not given their fluids in the correct format according to assessments carried out by the relevant healthcare professionals such as the Speech and Language Therapy (SALT) team. The lack of information provided to staff with regard to this placed people with swallowing difficulties at serious risk of harm.

We observed another person repeatedly ask a member of agency staff for a biscuit. The member of staff told them they were unable to have biscuits but offered no alternative and continued to ignore the person's requests. We asked a permanent member of care staff on duty if there was a reason the person could not have a biscuit. They replied, "No, I don't think so." We asked the senior carer on duty who explained that the person had a swallowing reflex problem and was not able to have a biscuit. The most recent update in the person's eating and drinking care plan did not mention a swallowing difficulty. However, further back in the care plan it was recorded that they had been coughing when drinking fluids and a thickener had been prescribed. This information was not clearly available for staff which put the person at risk of choking if food and fluid was given in the wrong format. In addition to this there was no risk assessment in place with regard to choking to indicate that this risk had been considered and guide staff as to how they could reduce this risk.

The log of accidents and incidents in the service was incomplete. Accident and incident reports were unorganised and did not always demonstrate what actions had been taken to mitigate further risk following an incident. Risk assessments were not always updated to show changes in peoples assessed health and welfare needs and associated risks. Where records had been updated, the information provided to staff was brief and did not give clear guidance as to how they could effectively mitigate the risk of harm.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely. Individual risk assessments were either not in place or not effective. Care planning strategies were not in place in relation to people's dementia related needs, moving and handling, nutritional needs, skin integrity and prevention of pressure ulcers, catheter care or end of life care. Staff did not have guidance on the support people required to meet these needs and keep them consistently safe. For example, a pressure cushion had been arranged by the community matron for one person at risk of developing pressure ulcers and was in place on their bedroom chair. However, there was no care plan document in place and limited risk assessments in relation to the person's pressure care needs to guide staff . On the second day of our inspection we observed that this person sat in a lounge chair throughout the day without a pressure cushion in place. This exposed them to risks associated with poor skin integrity and pressure ulcers.

The care records of one person on a short term placement at the service gave staff limited information on their needs, risk or how to deliver their care. A pre-admission assessment stated that the person had epilepsy however there was no care plan or associated risk assessment in relation to this. Care records for the person did not include history of any past seizures or guidance for staff to inform them whether or not the person was at risk of seizure and what action to take should a seizure occur. Without this knowledge there was a potential serious risk that the person's needs would not be met and could come to harm.

People were not protected against risks associated with poor infection control. We observed that staff were not always following guidance given in the providers infection control policy when providing care to a person with an infectious condition. A member of staff was seen to remove their disposable apron & gloves on leaving the persons bedroom. A senior member of staff intervened and reminded them to dispose of the gloves and apron correctly before leaving the room. The person's care plan had not been updated regarding their condition and it was unclear how staff were being kept informed regarding this. Another person told us of an occasion when they needed assistance to be washed. Staff had been unable to clean them properly following use of the toilet as there were no gloves the correct size anywhere in the service. A member of staff confirmed that there had been an occasion when they had run out of gloves as they had not been ordered in time. This put people and staff at risk of cross contamination and the spread of infection.

Poor practice regarding the use of protective aprons put people at risk. We observed that staff had put tabard style aprons on to three people in order to protect their clothes whilst eating. These were not of a type to enable quick release should they become caught and hung over the back of people's chairs. There was a risk that the material could be caught in the handles of people's wheelchairs or risk of other people pulling the back of the bib intentionally or un-intentionally. This placed people at risk of entrapment or strangulation. We pointed out to a member of staff that this was a concern and they assisted one person to tuck the back of the apron in behind them. Despite this, we found that later in the day people's aprons were still hanging over the backs of their chairs.

We checked people's medicines administration records which appeared to be completed correctly to show that people had been given their medicines as prescribed. However, we were concerned that the member of staff completing these records on the first day of our inspection was doing so retrospectively at the end of the medicines round. When we discussed this with them they acknowledged that this was not best practice and that peoples individual medicines records should be completed as soon as possible after

administration of the medicine and before moving on to the next person. Staff told us that the medicine round often took longer than it should because the lack of staff meant the senior member of staff administering the medicines had to stop to provide additional support to the care staff. This meant there was a greater risk that people would not receive their medicines as prescribed if accurate records were not made at the time their medicines were given to them.

There were no protocols in place for medicines which were prescribed to be taken 'as and when required' to guide staff as to when these should be administered. This meant that staff may not be aware when a person needed medicine such as pain relief because there was no guidance to show how people communicated that they were in pain when they were able to verbalise how they were feeling.

This continued to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection in June 2016 records showed that one to one supervisions were not taking place regularly. Supervisions give staff the opportunity to talk through any issues, seek advice and receive feedback about their work practice. The management team had acknowledged that supervisions had not been taking place as often as they should and told us of their plans to put a more structured system in place involving other senior members of staff.

At this inspection we found that this system had not been put in place until very recently when the nominated individual for the service had taken on this responsibility. Supervisions which had been completed by the nominated individual included observations of staff whilst providing care and administering medicines and promoted good practice by offering guidance and support. Whilst this was a positive step forward we were concerned that until supervision of all staff had been completed, poor practice within the service had been allowed to continue which put people at risk.

Training records had not been kept up to date which meant the manager was unable to assure themselves or us that all staff had completed the training they required. Staff told us that they did receive training in key areas such as moving and handling, medication and dementia care. However, staff had not received training specific to the support needs of the people they cared for. For example, staff cared for people with swallowing difficulties but they had not received training to enable them to recognise and meet those people's needs more effectively. This meant that staff had not been equipped with the knowledge they needed to support people with these conditions safely and consistently.

This continued to be a breach of Regulation 18 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions.

Staff were not always working within the principles of the MCA. We observed that staff did not always ask people's permission before they provided any support or care. For example, staff were seen to put aprons on people without asking them first. One person told us that they had refused to take one of the medicines

prescribed to them that morning as they had not been made aware what it was for. We were told by staff that this was an antibiotic which had been prescribed due to the results of a urine test which indicated an infection. However, the results of the test and subsequent prescription for antibiotics had not been discussed with the person. The medicine was therefore not being given in line with the principles of the MCA as the person had not been consulted before administration was attempted.

This was a breach of Regulation 11 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014

At our last inspection we found that the meal time experience was not a positive one for many. At this inspection we found that the meal times had not improved and also found that standards relating to meeting peoples nutritional and hydration needs had dropped.

There was insufficient monitoring of peoples nutritional and hydration needs. One person's care plan showed that they had a very limited intake of food or fluid. However, there was no system in place to monitor their fluid intake. A food chart was in place but of little value as there was no evidence that this was being monitored. Care staff were seen to leave a full plate of food in front of the person and then collect the uneaten plate at the end of the lunch period. This persons care records did not provide guidance for staff to know how they should be supported with meals or details of preferences which may encourage them to eat. Without appropriate monitoring or information to guide staff when further intervention may be necessary the person was at severe risk of dehydration and malnutrition.

This was a breach of Regulation 14 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014

On the first day of our inspection all but one person ate their meals in the lounge rather than the dining area. We asked the manager the reason for this and was told it was their choice. However, tables were not laid ready for lunch and we did not observe that people had been encouraged to come to the dining area. This meant that many people remained in the same place all day without moving from their lounge chairs. This was a concern as it meant an increased risk of problems associated with lack of movement such as poor skin integrity and decreased mobility. It also meant that people missed the opportunity to get a change in their surrounding and socialise together over their meal.

Some people did come to eat their meals in the dining room on the second day of our inspection. The nominated individual had recognised that this was important to people's health and well-being and should be encouraged if people chose to eat at the table rather than in the lounge area. However, the lunch service was disorganised and there were not enough staff to be able to support people with their meals. People needing assistance had to wait whilst others around them were eating their meals. This meant that some people became unsettled and anxious and the mealtime experience was not a positive and enjoyable time.

People's feedback about the food was mixed. One person told us how they felt about their meals, "It's gone downhill, always the same, it's never brilliant. No real choice, only an alternative offered, usually stew, mince, stew. Fish and chips on a Friday." Another person commented, "It's OK here". A relative said, "[Person] enjoys the food, but it is all the same not much variety". One person commented that they liked a banana every day but that they had not been able to have one for the last few days as they had run out. A member of staff said, "They don't get as much fruit now. It isn't being ordered." Further discussion with other members of staff told us that stocks of certain foods at times ran out because of the lack of organisation and co-ordination with regard to food orders. On the second day of our inspection the service ran out of tea-bags and a member of the care staff had to leave the service to get these. This meant that staffing levels

were further reduced for this time.

People had access to health care services and received on-going health care support where required. However they could not be assured that the guidance given by health care professionals would be followed to ensure they received safe and effective care and support in line with their current healthcare needs. For example, food given in the correct form as recommended by the SALT team or ensuring that pressure relieving equipment was used.

Inadequate

Is the service caring?

Our findings

At our last inspection we found that people's dignity was not always upheld. At this inspection we found that the provider had not made the improvements required to ensure the service promoted a caring and respectful culture. A relative told us, "They [staff] all seem to be very nice people but I think they haven't enough of them. You can't knock any of the staff." Another relative told us, "I would describe the staff as being more reactive than proactive". Although staff were caring in their approach, their daily routines did not promote a culture which supported people with all of their physical, psychological and emotional needs.

Although people said staff were caring and kind, staff had not been equipped with the appropriate knowledge to help them to understand the needs of people. Care staff were not supporting people in a consistent and planned way. This, therefore, placed people at risk of receiving inappropriate and poor care.

People's support was not led by the needs and preferences of the individual. For example, staff spoke about supporting people to use the toilet. One member of staff explained, "Those that get up late are toileted at the start of the afternoon shift." This demonstrated that assistance was being given according to the timeframes available within a shift rather than when a person actually needed the support.

Despite this task led approach, people felt that the permanent members of staff knew them well. One person told us, "They [staff] are always in a hurry, but they know you, they are kind and friendly, they know what we used to do, where we worked." However, agency members of staff knew people less well. A relative commented, "The staff have a good dialogue with [person], not so much with the agency staff they employ." Another relative said, "I'm not convinced they know my [relative] well enough. This is their home but it's like having strangers in." Our observations confirmed this. We observed two agency staff serving drinks in the lounge. They did not know people's names or preferences and focused on the task of serving drinks with little other interaction or attempt to find out more about the people they were supporting.

The task focussed approach also meant that people were not always given the opportunity to decide where in the service they wished to be. One relative explained how a person would have liked to watch television in their own bedroom at times but they felt that this was discouraged. They commented, "If they can go in to their own room and have the TV on they should be allowed. I get the impression they're down here all day which they are."

People were not always supported to be actively involved in making decisions about their care. One person told us, "A [healthcare professional] came to look at [health condition]. I haven't a clue in what [healthcare professional] was saying, so I asked the staff but they said that they were going to tell my [relative]". The person had not been given the opportunity to discuss the options available to them or given information about their condition in a way in which they would understand.

We were concerned that people's privacy was not always respected. On our arrival on the first day of inspection we noted that empty trays which had previously contained people's medicines were stacked up by the front door. Labels on each tray contained personal information about each individual which was a

breach of confidentiality. We discussed this with the manager who arranged for these to be removed.

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

Inadequate

Is the service responsive?

Our findings

At our last inspection we found that although an activities co-ordinator was employed to provide three hours of activities Monday to Friday, there was a lack of general activity for much of the day. At this inspection we found that this situation had become worse. The activities co-ordinator was now working care shifts due to staff shortages the majority of the time. There continued to be a lack of meaningful activity and mental stimulation.

Opportunities to participate in activities were limited and activities provided were not personalised or tailored to meet people's level of ability, choice or preference. Staff did not have the time to engage in activities with people to enhance people's well-being. One person told us, "I feel totally forgotten here. I feel this is just a roof over my head and somewhere to sleep. That sums the lot up." A relative told us. "[Person] doesn't seem to do anything all day. I suppose it's down to staffing levels. They are busy. It's not nice people just sitting there." Another relative commented, "I've been looking at charitable organisations who provide a befriending service. I shouldn't have to do that."

People told us how they would like the opportunity to go out more. One person said, "I'd like to go out, maybe to The Barn down the road but we don't go out." A relative told us, "I do think they should be able to get out in to the garden more." A member of staff explained, "We used to take people out for a walk in the wheelchair but we can't spare the staff. We have an activities [member of staff] but they are on care. People like staff just to sit and chat to them but that is something they don't get."

There continued to be a lack of resources to support people with physical or mental stimulation appropriate for people living with dementia or other mental health conditions. A member of staff told us, "A lot of people need to be having one-to-one. There just isn't enough staff to do that." We observed one person sitting at a table all day facing the wall. The table had a few activities placed on it but staff did not actively attempt to encourage them to use the items on the table or engage with them other than assisting with their meal at lunchtime.

At our last inspection people told us that they received personalised care which was responsive to their needs and that their views were listened to and acted on. We also found that care plans had been regularly reviewed and updated in response to changes in people's support needs. However at this inspection we found that the standard of the care plans had deteriorated and they had not been fully reviewed since February 2017. People were not receiving care that was personalised and there was no consistent and planned approach to support people.

Care plans were incomplete, inconsistent and task led. There was a lack of clear guidance and key information for staff to enable them to support people with their specific health conditions such as swallowing difficulties, epilepsy or conditions which may be contagious and put others at risk. Therefore staff did not know the signs and symptoms to be aware of, or their relevance to indicate a risk to the person's health, safety and wellbeing and may not recognise the need to take action in order to prevent them from becoming seriously unwell.

Staff did not understand the reasons people became anxious or upset. There were no details in peoples care plans to tell staff about triggers that might make this worse, or ideas about how to distract or engage positively with them. Without this understanding staff were unable to provide person centred care to ensure people's well-being. One relative told us, "They tend to leave the residents where they are put. They leave the noisy ones alone and separate from the other residents." Another relative told us, "There are lots of people calling out. They put them round the corner." One person shared with us how they felt about spending time in the communal areas,
"I go downstairs to do the odd activity but come back upstairs as some of the residents are too noisy and shout."

A health and social care professional told us, "I've spoken to staff a few times about [person's] behaviour. I'm not sure I got the best information. The manager was very helpful and said that the carers could deal with the behaviour but [member of staff] said [person] is so aggressive, so angry and very demanding." An entry in this persons daily notes read, "Confused all afternoon. In and out of lift, rude when staff approached." Another person's notes said, "Has been quite rude to staff." There were no details about why this might be or what could be done to help support people in situations such as these. The lack of understanding and action from staff meant opportunities were missed to reduce anxiety levels and prevent distress and social isolation escalating.

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

There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. Records of previous complaints showed that they had been investigated and responded to. However, it was not clear how feedback received had been used to put things right and make improvements to the service. For example, one complaint related to concerns that a person had not been supported to use the toilet in a timely manner but the feedback we received from people, relatives and staff told us that this was still a concern.

Inadequate

Is the service well-led?

Our findings

Despite assurances from the provider that improvements would be made following our inspection in June 2016, there continued to be widespread shortfalls in the way the service was led. There was a lack of managerial oversight at all levels and leadership was not pro-active. One member of staff commented, "There is no firm leadership. It's like a domino effect." There was a failure to recognise and identify failings impacting on the quality of service provision.

The provider continued to fail to ensure that there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively.

At our last inspection we found that a dependency tool to calculate staffing levels was used but this had not taken into consideration all of people's care and support needs and was unrealistic in its assessment that there were adequate staffing hours allocated. This continued to be the case and the situation had been made worse by further admissions to the service of people requiring a significant amount of support without fully considering the additional staff which may be required to meet people's needs..

Following our last inspection we had informed the provider of our concern that they lacked insight into areas where improvements were needed. At this inspection we found that a director now visited the service more regularly to carry out audits of the service provision. Monthly audits had also been carried out by the nominated individual on behalf of the provider. However, these audits were ineffective as they had failed to identify concerns we found on inspection and the multiple non-compliance with the Fundamental Standards of Quality and Safety. Audits did not give clear information to show who was responsible for actions, what timeframe they should be completed in or how outcomes should be monitored and maintained. Without this oversight the provider had failed to ensure that improvements were being embedded, capable of being sustained and that future shortfalls would be identified, appropriate action taken and lessons learnt.

Staff continued to be unclear on their roles and responsibilities and how they contributed towards the provider's vision and values. Staff were not effectively deployed and provision of care was task led rather than centred on the individual needs of people. There was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met.

Staff told us that morale was low. They did not feel that they were motivated or supported by the provider and were reluctant to report bad practice due to fear of recrimination. The registered manager and staff were under pressure to work additional hours. One member of staff told us, "The manager often comes out on the floor to assist staff. [They] have been doing that a lot lately, as we don't have enough staff to see to the higher needs residents." Another member of staff commented. "I do enjoy working here but I sometimes feel pressurised in having to cover shifts on top of my off duty due to sickness or when there is no agency." A third staff member said, "Staffing is awful. Disgraceful. A lot of the staff are exhausted."

Staff told us that when concerns about additional hours or not being able to take breaks had been raised with the provider they had been told they were all, "Lazy." A member of staff told us, "You are not appreciated for what you do. If you bring anything up with [provider] you are told you can get a job somewhere else." Staff felt they could approach the registered manager if they had concerns but felt this made little difference as nothing changed. One member of staff said, "I'd go to [registered manager] if I had any concerns. I think [they] would take them on board and take to [provider] but it goes no further. Nothing gets done. If you come forward you would be penalised for it."

Following the second day of our inspection we were informed by the provider that the registered manager had resigned. We met with the provider on 7 September to discuss their future plans for the management of the service. A replacement manager had already been employed and commenced employment on 20 September 2017. However, they also resigned two days later and informed us that the provider had unrealistic expectations with regard to the management role. They were concerned that there were not enough staff to meet people's needs but were not confident that action would be taken by the provider to remedy this.

We were concerned that management arrangements within the service were unstable and therefore visited the service again on 26 September 2017. The registered manager was to remain in post for the next two months and the nominated individual was to provide oversight. However, they were due to go on holiday later that week. The provider informed us that it was the intention that the nominated individual would be working full time at the service until a new manager was found. However, we were concerned how the urgent changes needed to ensure people receive safe and effective care would be made. We took urgent action to request specific information regarding the leadership of the service and implementation of the improvements needed.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff reported to us that they had been reluctant to raise concerns as they believed that the manager would not take appropriate action. A member of staff told us that there was no consequence for any action by staff and appropriate disciplinary action did not take place. There was also a belief amongst some staff that they would not be supported to raise a concern as the provider had previously told others that they could look elsewhere for a job if they did not like the way that things were being done.

The reluctance to report issues and concerns which may constitute abuse is of serious concern as this demonstrates a poor culture within the service and may mean that potential mistreatment, neglect or risk of serious harm is not reported to the appropriate professionals to be investigated. This placed people at risk of unreported abuse.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were incomplete, inconsistent and task led. They had not been effectively updated to reflect people's current care needs.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not always support people in line with the Mental Capacity Act.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.

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 had not been co-ordinated or

	managed to ensure their specific needs were being met safely.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.

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 Staff were reluctant to report issues and concerns which may constitute abuse.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always supported effectively with their nutritional needs.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of managerial oversight at all levels and leadership was not pro-active. Robust and sustainable audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	There were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm.