Little Oyster Limited

Little Oyster Residential Home

Inspection report

Seaside Avenue
Minster-on-Sea
Sheerness
Kent
ME12 2NJ

Tel: 01795870608

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Little Oyster Residential Home accommodates up to 64 people across three buildings. The main building is divided into two floors and annex, and there are separate bungalows and flats where people live more independently. The service accommodates people who have learning disabilities, mental health conditions and physical disabilities. The service was providing personal care to 52 people at the time of the inspection.

People's experience of using this service and what we found
People were not always safe at the Little Oyster Residential Home. Comments included, "This place is needing sorting out, they are putting on a façade because you are here. I feel unsafe here because of the staffing levels"; I want to move. Between you and me I feel very unsafe – I can't sleep or settle"; "[A person] has started banging on my window late at night, I have reported it to staff, it scares the life out of me" and "I feel safe but there is not enough staff, they don't have cover for sickness which means they run short."

The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection. Timely action had not been taken to address issues identified within audits. People were at risk because the provider had not acted to ensure they had sufficient oversight of the service. Records were an area of concern across the service; records were not complete and accurate and had not always been stored correctly. The provider had failed to sustain the improvements and the service had declined in quality.

The provider had not developed an open and honest culture where staff were empowered to raise any safeguarding concerns. People were not protected from harm and abuse.

Risks associated with diabetes, epilepsy, catheter care and constipation had not been robustly assessed and action had not been taken to reduce risks to keep people safe. Some risk assessments were generic and did not relate to the people they were about. People were not protected from the risks in the event of a fire. Fire risks had not always been well managed.

There was a poor system in place in relation to accidents and incidents. Accident and incident records evidenced that timely and appropriate action had not always been taken to address incidents.

We were not assured there were enough staff to meet people's needs. We observed call bells were not always answered quickly. We also observed that call bells were muted or switched off without staff attending to people to find out what they wanted or needed. Staff were not always recruited safely.

Medicines were not managed safely. Policies and processes for managing medicines were not always followed. Thickening agents prescribed for people who had swallowing difficulties were not always measured accurately when added to liquid medicines. Records were not always made when people's medicines patches were removed or where on the body they were applied. Large amounts of unwanted

medicines, clinical waste and other containers had not been appropriately disposed of.

The cleanliness of the building had declined, people were at risk from the spread of infection. Government COVID-19 guidance had not always been followed in relation to testing people and staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's care plans contained conflicting and confusing information about their mental capacity. It was not always clear when a person lacked capacity and when a best interests decision had been made, who had been involved in the decision making process.

Training records evidenced that some staff had not completed their training to give them the skills and knowledge of safely working with people. A large selection of staff employed were not listed on the training records, which indicated that they had not received any training

People told us that the meals were of poor quality and lacked vegetables and were not balanced. Some people told us they did not always get choices of meals and some said they didn't know what meal choices were on offer until the food was brought to them. Food and drink did not always meet people's assessed needs.

People had not always had access to medical appointments for their health needs to be met. People's health records evidenced that several people had not seen their dentist since 2019.

Maintenance tasks had not always taken place in a timely manner, which could put people at risk of harm. We observed there were areas of the service that were not clean; carpets were stained and dirty in places, bathroom, toilets and ensuite floors were dirty and stained in places and there was an unpleasant odour. Some equipment was visibly dirty and had not been cleaned.

Prior to people moving to the service their needs were assessed. Assessments included oral healthcare. During the inspection we found that some people who required physical assistance to maintain their oral hygiene had very poor oral hygiene. People were not consistently receiving good care. Some said they were happy living at the service, and some were deeply unhappy and asked us for help to let their social workers know that they wanted to be moved.

People were not always treated with dignity and respect. People's personal records were not always stored securely to ensure they were only accessible to those authorised to view them. People's cultural needs were not always respected. Some people were not always supported to maintain important relationships with people when they could. Most people told us the staff were nice and kind.

Some people told us their personal care needs were not always met. People's care records did not always evidence people had received personal care (including oral care). Care and support plans for people with long term conditions lacked detail. There were no activities taking place in the service. People told us they were bored and had nothing to do.

The provider had not followed their own complaints processes, timely action had not been taken to address people's concerns.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for

granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
People's choice was not maximised, and they could have been better supported to develop more control and independence.

Right care:
Care was not always person-centred and promotes people's dignity, privacy and human Rights. People had not always received the care and support they had been assessed to require.

Right culture:
Ethos, values, attitudes and behaviours of leaders and staff did not ensure people always lead confident, inclusive and empowered lives.

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

Rating at last inspection
The last rating for this service was Good (published 04 May 2021).

Why we inspected
The inspection was prompted due to significant numbers of concerns received about staffing levels leading to lack of care towards people, medicines management, infection control, COVID-19 testing and the mismanagement of records. A decision was made for us to inspect and examine those risks. As the risks spanned across all five domains, the inspection was a comprehensive inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to: risk management, medicines management, safeguarding people from abuse, management of infection control, safe staffing levels, staff training, ensuring adequate nutrition and hydration, safety, maintenance and cleanliness of the premises, ensuring people received person centred care and support, treating people with dignity and respect, management of complaints, providing activities to meet people's needs and ensuring systems and processes are operated effectively to assess, monitor and improve the quality and safety of the service at this inspection.

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

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Little Oyster Residential Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by four inspectors (including a medicines inspector) 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
Little Oyster Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. We also spoke with a whistle blower about their experiences of the service. We reviewed feedback submitted in writing from whistle blowers and the provider's response to the initial concerns raised.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 16 people who used the service about their experience of the care provided and seven relatives. We spoke with 19 members of staff including the nominated individual, deputy manager, team leaders, senior support workers, support workers, a cook and a member of the maintenance team. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed staff interactions with people and observed care and support in communal areas.

We reviewed a range of records. This included eight people's care records and nine medicines records. We looked at three staff files in relation to recruitment, staff supervision and training. A variety of records relating to the management of the service, including checks and audits, fire safety and maintenance records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance, training records, rotas, sickness records, COVID-19 testing records and maintenance records. We spoke with a further two people and one relative about their experience of the care provided and a range of health and social care professionals. We also sought urgent assurances from the provider relating to staffing levels, COVID-19 testing and management of the service. We were not assured with the responses received so took urgent enforcement action.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At the last inspection in April 2021, risk assessments were inconsistent. Risk assessments of people's pressure areas had not been accurately completed, which resulted in people being wrongly assessed as a lower risk of developing pressure ulcers. Risk assessments relating to the administration of laxative medicines were not clear to detail when staff needed to administer the medicine. At the last inspection each person's emergency evacuation plan (PEEP) which should describe the support they would need to leave the building in an emergency did not detail what staff should do to support each person.

● At this inspection, risk assessments had not improved. They did not provide clear guidance to staff about how to meet people's needs safely; epilepsy risk assessments did not include additional risks to people and how these can be mitigated. One person's epilepsy care plan identified triggers to their epilepsy but these triggers were not recorded in risk assessments.
● Risk assessments for people who suffer with constipation were not in place, so staff did not have all the information to be able to provide safe care and support. Diabetes risk assessments were not clear for staff to know and understand what actions they should take to support people to manage their diabetes. Catheter risk assessments and associated support plans contained no information for staff about risks to a person such as the risks of infection, blockage and infection control risks. This meant that staff did not have information about the signs and symptoms to look out for. Risk assessments did not provide staff guidance about who to report concerns to.
● There were inconsistencies with risk assessments. Some were very detailed, and some did not cover the risks and how to mitigate these. Some risk assessments were generic and did not relate to the people they were about. For example, sun burn risk assessments were in place for every person, however the signs and symptoms of sunburn for people with black skin had not been considered.
● Risks of harm had not always been considered. We observed one person was at risk of injury as their bed did not have a bumper covering the bed rail. We reported this to the acting manager who took action to address this. There were risks to choking across the service as the safe storage of thickener had not been followed.
● Fire risks had not always been well managed. There was a build-up of items in storage which could be a fire hazard, some fire escapes were not closing correctly. A significant number of staff had not attended fire drills. Fire drills had not taken place since November 2020 and were not practiced, based only on theory, which meant the provider had not assessed whether staff were able to successfully evacuate the building following their training. We found evidence of unsafe practice occurring in relation to one person who was being locked in their flat at night with no way of exiting if there was a fire. A fire risk assessment had been

carried out by a contractor in May 2021, the assessment contained several actions which had not been addressed. We reported our concerns to the fire service.
● PEEPs had not improved since we last inspected. This meant that staff (including new staff and agency staff) may not know how people respond to the fire alarm sounding and how to evacuate each person safely.
● There was a poor system in place in relation to accidents and incidents. Accident and incident records evidenced that timely and appropriate action had not always been taken to address incidents. People who had frequently fallen had not been referred to medical professionals such as the falls clinic or their GP/consultant. No analysis had been carried out for people who lived with epilepsy and had frequently fallen.
● Records relating to accidents and incidents were not always clear. We observed one person on the first day of our inspection with an injury to their face and head. They told us this had happened the night before. There was no accident record of this incident.

The provider had failed to protect people from risks related to fire and the environment. Risks related diabetes, catheters, choking and epilepsy had not been assessed and care had not been planned to keep people safe. Accidents and incidents had not always been responded to and reviewed to. This placed people at risk. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Before we inspected, we received complaints and concerns about unsafe staffing levels. At the inspection, we were not assured there were enough staff to meet people's needs. The provider's rota system made it extremely difficult to ascertain who was working and who was not. The acting manager was unsure of which staff were working and which staff were off.
● After the inspection we asked the provider for further information regarding staffing levels. We were not assured with their response and took urgent action to make sure people were safe. The staffing levels had dropped with staff leaving to find alternative employment and unsuccessful probation period, these issues were unrelated to the COVID-19 pandemic.
● We observed call bells were not always answered quickly. We also observed that call bells were muted or switched off without staff attending to people to find out what they wanted or needed. People told us this was frustrating. One person said, "Staff do not come quickly when I buzz and I wait sometimes for 15 to 20 minutes, which is a long time when you need the toilet." Another person detailed they had used their telephone to call the office on one occasion to request physical help to get out of bed as no staff had been in to them to support them. Other comments included, "Sometimes staff seem a little rushed" and "Staff haven't got the time to do anything, they don't have time to spent with me, they used to be able to come in and spend time with me. They can't blame [previous registered manager] anymore she has been gone 2 months."
● Relatives told us, "Never quite enough staff" and "In the past I used to see regular staff, now only one regular."

The provider had failed to deploy staff sufficiently. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

● Staff were not always recruited safely. Staff recruitment records showed gaps in one member of staff's employment history. These gaps had not been addressed and recorded. This is an area for improvement.
● Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from

working with people who use care and support services.

Using medicines safely
● The service had policies and processes for managing medicines (including ordering, storing, administering and disposing of medicines). However, these were not always followed. For example, staff recorded that controlled drug checks had been completed. Our checks identified discrepancies in quantities of controlled drugs against records.
● Thickening agents prescribed for people who had swallowing difficulties were not always measured accurately when added to liquid medicines. This meant there was a risk of the person choking.
● Records were not always made when people's medicines patches were removed or where on the body they were applied. This meant that the site of application may not have been rotated and could cause irritation to the skin. The records did not evidence that staff had carried out checks to ensure the patches remained in place. This meant that a person could be without their medicine.
● Care plans were not always updated with current information about people's prescribed medicines. This meant inaccurate information could be given to healthcare professionals involved in the care of the person.
● Fridge temperatures were not recorded in line with national guidance. For example, maximum and minimum temperatures within 24 hours were not measured. We found two fridges contained a significant build-up of ice on the outside of the freezer compartments and staff had not taken action to defrost them. This meant that medicines may not have been stored at the appropriate temperatures and could be less effective.
● Staff recorded people's unwanted medicines. However, we found large amounts of unwanted medicines, clinical waste and other containers that had not been appropriately disposed of.

This demonstrates a breach of Regulation 12 (Safe Care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received medicines training and were assessed to ensure they were competent in the safe administration of medicines. Staff reported and investigated medicines errors.

Preventing and controlling infection
● We were not assured that the provider was accessing testing for people using the service and staff. The provider had failed to test staff and people and were not following government guidance on testing in care homes.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the service were dirty and had not been cleaned effectively. Cleaning schedules had not included cleaning of high touch areas and any additional cleaning to maintain robust cleaning standards.
● We were not assured that the provider's infection prevention and control policy was up to date.

This demonstrates a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse

● The provider had not developed an open and honest culture where staff were empowered to raise any safeguarding concerns. Before the inspection, we received whistleblowing concerns from staff who told us the management team were not approachable and did not always listen or act where necessary. Staff did not feel assured they could raise concerns within the service and relevant action would be taken. Staff reported concerns outside of the organisation to CQC instead.

● People were not protected from harm and abuse. Some people told us they did not feel safe living at Little Oyster Residential Home. One person told us they had been verbally and psychologically abused by staff at the service. We informed the local authority safeguarding team who started investigations. Fire safety concerns put people at risk of harm. One person had been locked in their flat each night without any way of getting out if there was a fire. We reported this to the acting manager as an urgent action and also reported our concerns to the local authority safeguarding team and the fire service.

● Other people told us, "My main concern is staff, they are doing too many hours and making mistakes. They are putting my life in danger and others. I feel unsafe here because of the staffing levels" and "I don't feel safe, between you and me I feel very unsafe."

The provider had failed to protect service users from abuse and improper treatment. This placed people at risk. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Training records evidenced that some staff had not completed their training to give them the skills and knowledge of safely working with people. A large selection of staff employed were not listed on the training records. It was difficult to ascertain exactly how many were missing and required training due to the staffing records maintained by the provider being poor. De-choker training was not included on the training list, but people's choking risk assessments stated staff were trained.
- We raised concerns with the acting manager about the content and structure of epilepsy and administration of Buccal Midazolam training. We were not assured by the acting managers response to the concerns and training records did not verify the information. We attempted to contact the training provider on several occasions to seek some clarification. We were unable to gain a response.
- Before the inspection, we received whistleblowing concerns that staff felt they did not have appropriate support to carry out their roles. These concerns continued to be reported during the inspection process.
- The staffing rota that the management team supplied us during the inspection process showed that a young person (under the age of 18) had been employed as a senior member of staff. This staff member had not long left full-time education and did not have the experience required to supervise and run shifts.
- Relatives told us, "A lot of young ones who are not experienced" and "They [staff] don't have the skills, too young, inexperienced and a high turnover. It is not their fault, it's the location."

The failure to ensure staff had the appropriate training to ensure people's needs were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People told us that the meals were of poor quality and lacked vegetables and were not balanced. They also said there was a lack of variety in relation to special diets. Comments included, "The food is basic and awful"; "No way I am getting my five a day in here, today there is chicken and chips no salad or greens, it's like school dinners"; "Food is nice I feel like I am putting on weight"; "It is not fit for human consumption". We discussed the lack of variety and fruit and vegetables with the acting manager who told us the service had followed a revised menu plan during COVID-19 due to availability of foods and they were now in the process of ensuring foods were reintroduced back in to the menu.
- Some people told us they did not always get choices of meals and some said they didn't know what meal choices were on offer until the food was brought to them. One person said, "If I don't like either of the choices, I am not offered a suitable alternative, just sandwiches are offered." We observed other people eating takeaway meals because they did not like to food that had been offered.

● Food and drink did not always meet people's assessed needs. Before the inspection we received whistle blowing concerns that people had been given drinks at a different consistency than they had been assessed as requiring. This was reported to the local authority safeguarding team. As part of the investigations carried out by the local authority one person was able to confirm that it had happened to them. However, they had not drunk it. One person's relatives had been contacted by the service to ask them to pay for pureed meals from an outside caterer, despite the provider being paid by the person's funding authority for residential care which includes food and drink.
● We observed people in communal areas drinking plenty of fluids and observed people in their rooms with their doors open had drinks within reach. One person told us they did not have enough to drink; they had no jug in their room and only gets drinks by pressing the call bell. They explained they didn't like to do this too often as they needed to press the call bell to summon help with their personal care. They said, "It is hot in my room, which makes me feel thirsty." We reported this to the acting manager immediately to ensure that the person is supported to drink plenty.
● One person living outside of the main building told us they had not been supported appropriately in 2020 during the pandemic and different lockdowns to shop for food. They reported the impact this had on them and we reported this to the local authority safeguarding team. The acting manager confirmed that the person had not been supported to shop for food.
● Fridges in communal kitchen areas were dirty and contained food that had not been appropriately labelled after it had been opened. This meant that people and staff using food from these fridges could not be assured it was safe for consumption.

The failure to meet people's nutritional and hydration needs is a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had not always had access to medical appointments in order for their health needs to be met. Healthcare professionals fed back that many appointments had been cancelled or missed because of a lack of availability of drivers to support people to appointments. During the inspection, we found diary entries that evidenced this was the case in June and July 2021. People also provided feedback to verify this had happened. Records showed this had affected routine hospital appointments and appointments with specialists, wheelchair services and occupational therapy. The acting manager told us this was due to two staff members out of 97, testing positive for COVID-19 and some had been cancelled due to a lack of drivers.
● People told us the cancellation of appointments was frustrating. One person told us about an appointment that was cancelled which they had been waiting for a very long time. They said, "It was cancelled because of the COVID-19 outbreak in the service. They didn't let me know it was cancelled, that is my main bug bear, the communication or lack of it." Another person told us; they had not been informed about their hospital appointment being cancelled by the service until they presented at the time they needed to leave. They were upset that this now meant they had to wait five months to see the specialist when they were experiencing chronic pain.
● Before the inspection, healthcare professionals shared that a number of people had clear and specific physiotherapy plans in place which required the staff to support with exercises. These healthcare professionals had provided training and guidance to staff to enable them to support people effectively and improve people's mobility and movement. Healthcare professionals shared that despite this being in place, each time they revisited people they found the exercises and physiotherapy had not been taking place and people's mobility had deteriorated as a result.
● After the inspection, when we were reviewing evidence and information, healthcare professionals shared

concerns that equipment that was in place to prevent a person's skin breaking down had not been used. This led to the person acquiring a serious pressure sore. They reported their concerns to the local authority safeguarding team.
● People's health records evidenced that a number of people had been assessed by Speech and Language therapists (SaLT) in relation to choking risks. SaLT had provided clear guidance in relation to food and drink textures to ensure people were supported to eat safely. The SaLT guidance was placed in people's health files. The guidance was not detailed in people's care plans or risk assessments, which meant staff (including new and agency staff) did not have all the information they needed to support people safely with their nutrition or hydration. Where SaLT guidance had been amended and changed by healthcare professionals this had not been picked up in the monthly review of people's assessed needs.
● People's health records evidenced that a number of people had not seen their dentist since 2019, despite dental services being open to non-urgent appointments during the pandemic. One person told us one of their teeth had fallen out overnight, they had not been supported to attend the dentist to get a check-up.

The failure to provide care and treatment to meet people's assessed needs is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The staff had called emergency services such as 999 and 111 when required to meet people's emergency needs.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People's care plans contained conflicting and confusing information about their mental capacity. Where it was deemed that action should be taken in their best interest, there was no evidence to support that the decision had been made in line with MCA 2005 Code of Practice and that the persons' rights had been properly considered.
● MCA assessments had been made for each decision. It was not always clear when a person lacked capacity, and when a best interests decision had been made, who had been involved in the decision making process. These best interests decision making processes should be made with relatives, relevant person's representatives and other professionals. One decision to move a person from one area of the service to a new unit had been made by Little Oyster staff only and had not involved the person's local authority care manager. The MCA assessment for this decision to move had not been fully completed so it did not indicate if the person lacked capacity or not.
● Where people had a DoLS authorisation, this was not clear in their care plans. This meant staff may not have the information they needed to understand people's legal status and make sure their rights were upheld.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team maintained a record of DoLs authorisations and applications which enabled them to monitor when they were authorised or due for renewal.

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

● Maintenance tasks had not always taken place in a timely manner, which could put people at risk of harm. Contractors who had serviced the beds had identified several repairs that were required, these had not been signed off as actioned. The maintenance team checked the beds on our request and found that some of the repairs had been made. However, one bed had not been repaired, this bed needed a part to be ordered. Portable appliance tests had not been completed in the service since May 2020. Stickers on plugs in the service indicated that these were due to be done again in May 2021.

● There was no dementia friendly signage in place and way marking around the service, despite some people living with dementia. Some doors around the service had signs on them which did not reflect what the room was for. A bathroom on the top corridor was labelled as a bathroom, whilst there was a bath in it, there was a large amount of moving and handling equipment, specialist equipment and laundry trollies stored within in. The room opposite this bathroom was also labelled as a bathroom. This room was locked and was found to contain medicines, sharps and boxes. All the bathroom equipment had been removed.

● We observed there were areas of the service that were not clean; carpets were stained and dirty in places, bathroom, toilets and ensuite floors were dirty and stained in places and there was an unpleasant odour. Some equipment was visibly dirty and had not been cleaned. Cabinets within communal areas that were used to store people's prescribed thickener were dirty.

● Several people told us about repairs that had remained outstanding which included, cracked toilet bowls, cracked tiles in ensuite bathrooms, holes in ceilings and walls. We observed damage to electrical sockets in people's rooms had not always been prioritised for repair, one person's socket had been taped up for some weeks. We observed toilet cubicles in one area of the service were stacked with unwanted items, the door could not be closed so it had been wedged shut with a chair. There were holes in walls which remained after previous works had been carried out and areas where people could access hot pipes.

● People knew their way around the service and were seen actively finding their way to lounges, dining rooms and their bedrooms as well as outside if they were smokers. People's rooms had been decorated and furnished to their own tastes. Corridors and rooms were roomy. One person had recently moved to a smaller room in a different part of the service. A large selection of their personal belongings including DVD's and posters were still in their old room. The room was not locked and open which meant other people had access to their personal belongings. Staff were also using the room to store their own belongings.

The failure to ensure the premises is suitable for the purpose it is being used is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Prior to people moving to the service their needs were assessed. These assessments were used to develop the person's care plans. The assessment included people's protected characteristics under the Equality Act (2010). For example, their religion, culture, health needs and their abilities.

● Assessments included oral healthcare. During the inspection we spent time with people and carried out discreet checks on people's oral hygiene. We found that some people who required physical assistance to maintain their oral hygiene had very poor oral hygiene. Staff told us one person was independent with their oral hygiene. This person had already told us they had not brushed their teeth because they had no

toothbrush. We helped them search for it and it could not be located. Staff also then began to look. Staff had not provided prompts and encouragement to the person to support them to remain independent with their oral hygiene. The person did eventually find their toothbrush and was encouraged to use it to brush their teeth.

● People and their relatives did not always feel fully involved and kept up to date with assessment processes. One person told us they would like to be involved with reviewing their care and support plans and risk assessments.

● People's assessments had not been reviewed and updated when their needs changed. For example, when people's mobility had changed which meant they spent prolonged periods of time in bed or their wheelchair, skin integrity risks had not been reviewed and updated. This meant people may be at risk of pressure damage to their skin.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- At this inspection the rating was inadequate overall. This meant people were not consistently receiving good care.
- Not everyone could give us feedback about the service. Those who could provide feedback gave us mixed views. Some said they were happy living there and some were deeply unhappy and asked us for help to let their social workers know that they wanted to be moved.
- Some comments included, "No one asks how you are mentally, I have felt very down in here, especially being stuck in my room in lockdowns"; "This place is sucking the life out of us, I feel when asking for things I have to beg. This used to be a jolly place and nice to live, I wanted to die here because it is my home now I want to move"; "I want to move because of my health, it is getting extremely bad as well as my mental health, I like the staff. I am not getting personal care here; I do a wash myself. I can't take it anymore"; "Staff do not treat me like an adult, they come in and provide care but don't always respect my choices" and "I am not happy at all." We shared people's views with the local authority.
- People told us they felt staff did not have time to spend time with them. Some people were cared for in bed and relied on staff to engage with them to read to them and chat. One person told us, "Staff come in and spend time with me when they can, they often read to me."
- People were not always treated with dignity and respect. We observed people with no clothes on with just a sheet or blanket covering their private parts, doors were wide open, and people were on full view of other people.
- People's personal records were not always stored securely to ensure they were only accessible to those authorised to view them. On the first day of the inspection we found confidential records regarding people's health, hospital appointments and staff supervision records in a communal room.
- People's cultural needs were not always respected. One person told us they received support with their personal care in line with their wishes. Another person described the impact of staff treating them differently because of the country they were born in.
- Some people were not always supported to maintain important relationships with people when they could. During the COVID-19 pandemic people have relied on video calling and telephones to maintain contact with their loved ones. Not everyone living at the Little Oyster Residential Home had been enabled to do this because of poor WIFI signals in certain areas of the service. This had meant that relatives could not maintain contact and they were unable to get in contact with others when they wanted. People were unable to use the internet or social media as a form of mental stimulation. This had led to isolation for a number of

people. We fed back these concerns to the management team who advised they would upgrade the WIFI throughout the service to enable all people to maintain important relationships.

● Some people had expressed views about their care through surveys. Nine people had been surveyed in April 2021, the surveys showed they had fed back concerns including approachability of some of the management team, cleanliness of equipment and variety of meals. Their views and opinions had not been addressed. During the inspection, we observed dirty equipment and some people fed back that meals lacked variety and some of the management team were unapproachable.

● People's possessions had not always been respected. Two relatives gave examples of incidents where gifts that had been delivered to the service for their loved ones had not been received by their loved one.

The failure to treat people with dignity and respect is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were discreet when asking people if they needed to use the toilet. Staff ensured any support with personal care was carried out behind closed doors. We observed some nice interactions between staff and people, which showed that some staff knew people well, knew how to communicate with them and helped inspectors communicate with people.

● Most people told us the staff were nice and kind. Comments included, "The staff are not bad here"; "Staff are friendly and kind"; "Everyone is friendly"; The staff are all good"; "A lot of staff good" and "There is a cleaner who is nice." Relatives told us, "No-one is spiteful"; "They're caring and respectful, what I've seen of it"; "They're terribly friendly"; "The regular staff know him and he gets all excited and pleased to see them" and "They're polite and kind."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection in October 2019 of this key question, this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At the last inspection, care and support plans were not always person centred and were inconsistent. At this inspection this remained the same.

● Some people told us their personal care needs were not always met. People's personal care records did not always evidence people had received personal care (including oral care). One person told us, "I like to have a shower every day, but do not always get this. I have not had one today. I did have one yesterday." Another person said, "I am independent with personal care, but I need help to have a shave, I like to be clean shaven and this is not what I like (the person had an overgrown beard and moustache)."
● Some people had very long fingernails, two people reported this hurt their hands as the nails dug into the palms of their hands. We observed one person with very dirty feet, there was a build-up of a brown sticky substance between their toes. The person was not able to clean their own feet. They told us, "I can't reach."
● Care and support plans for people with long term conditions such as diabetes lacked detail and people's blood sugars were not always monitored.
● Some people's diet and nutrition care and support plans contained conflicting information. One person's recorded that they were on a softened food diet, then later referred to pureed food. The same person's plan detailed that the person had normal consistency in their drinks and then stated they had two scoops of thickener per 200mls of fluid. Staff did not have clear guidance about how to provide personalised, safe and effective care.

The failure to design care and treatment to ensure people's preferences and needs are met is a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● There were no opportunities for meaningful occupation taking place in the service during the inspection, people told us that activities did not take place. People told us they were bored and had nothing to do. Comments included, "I am not doing anything. There is nothing happening at all, no activities, I would like to be surrounded by people I know"; "There are no activities, it is like being in prison, we had a meeting yesterday and fed this back"; "There hasn't been any activities. I'm finding it boring. I do word searches and I have my phone"; "I choose to stay in bed and watch the news."
● Relatives said, "He has nothing to do"; "She doesn't have many trips out. She was told this was because

she didn't have enough money. I tell them that if she needs money just tell me. She's not going out enough. The activities people said, "We haven't got enough staff" now they're being used to take people to appointments" and "She is suffering, through lack of contact." The rota for the service showed only one activities staff member employed for the service. They were not working on the days we were at the service. Since the inspection, the provider has employed another activities staff member.

● One person living in the Pearl bungalow told us they wanted to go for a walk and had been asking all day and had not been allowed to. There had been two staff on duty in the Pearl bungalow to work with the four people living there. There was no reason why the person could not have gone out into the community for a walk.

The failure to ensure people's individual needs and preferences were met is a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had not followed their complaints processes when responding to complaints received. One relative had raised concerns relating to communication. The previous registered manager had met with them to discuss the nature of the complaint but had not formally responded to the complainant. We reported this to the management team.

● Some people and their relatives told us they would complain to the staff or the management team if they were unhappy about their care. Some people told us they didn't know who the manager was and how to complain. One person told us they would complain to the cleaner as they liked them and trusted them. Another person told us they would raise a complaint with their relative and ask them to take it forward on their behalf.

● During the inspection the acting manager carried out some meetings with people living at the service to hear their concerns. The acting manager told us that negative feedback had been received about activities, food and responsiveness of staff in providing personal care. Some of these issues had been raised by people in feedback surveys in April 2021. It was clear that timely action had not been taken to address people's concerns.

The failure to acknowledge, investigate and take action in response to complaints is a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

End of life care and support

● The service was not supporting anyone at the end of their life at the time of the inspection. A person had passed away the day before we inspected. It was clear that action had been taken to liaise with community nurses and the GP to ensure the person was comfortable and pain free. Relatives were able to spend time with the person and say their goodbyes.

● Relatives had written thank you cards and messages to the service in relation to end of life care. One read, 'Thank you and your team for looking after him so well and for taking care of [relative] this afternoon. It was always comforting when I drove home after seeing [loved one] to know he was in the good hands of LO staff.'

● The management team understood that if people's health deteriorated, they would seek advice and guidance from healthcare professionals to ensure people had the right care and support at the end of their lives.

● Some discussions had taken place with relatives to look at end of life wishes. Some people had a DNACPR (do not attempt resuscitation) in place which had been discussed and agreed with their relatives and consultants.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were known and understood by staff. People's support plans included details which helped new and unfamiliar staff learn about how people expressed their needs.

● Information was shared with people and where relevant, available to people in formats which met their communication needs. There were some visual aids around the service, for example informing people about complaints, staying safe from abuse, menu's and activities.

● One person's support plan had been translated into their native language.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. Audits had not picked up significant shortfalls in practices in relation to risk assessment, fire safety, infection control, COVID-19 testing, medicines management, staff deployment, meeting people's health needs, training, capacity and consent, dignity and respect, care planning, recording and complaints.
- Timely action had not been taken to address issues identified from audits. Infection control audits stated that artificial nails must not be worn. We viewed infection control audits from May 2021 which identified that staff had been spoken with about nail polish and false nails. During the inspection we observed several staff with long and false nails which puts people at risk of injury during personal care and these are an infection control risk.
- People were at risk because the provider had not acted to ensure they had enough oversight of the service. There had been a lack of provider and management oversight at the service which had caused issues with safe staffing levels, monitoring of practice and day to day management. We discussed this with the provider. During the inspection the provider advertised for a new manager. The manager that had been in post left the day before we inspected the service.
- Records were an area of concern across the service. Confidential records had not been stored securely; records were missing which made it difficult for inspectors to validate evidence. For example, rotas went missing and minibus mileage records were missing. Several records and action plans could not be located because they were stored on a computer that the previous manager had taken. Records were of poor quality and did not include a complete, accurate and contemporaneous record of care provided. Staffing rotas and staff signing in books did not correspond and the acting manager told us the rotas did not reflect who was on shift. Staffing lists did not include all staff and their contact details and the list of people living in the service was not accurate and up to date.
- Archived records were held outside of the service in a container on land owned by the provider. We were not assured by our discussions with the acting manager that the records retained in the container were stored, monitored and disposed of following data protection legislation. We advised the acting manager to seek advice and support from the Information Commissioner's Office (ICO).
- At the last inspection, there had been some improvements in some domains and breaches of regulations had been met. However, at this inspection, the provider had failed to sustain the improvements and the service had declined in quality. The provider advised that the decline was due to several changes in management since the last inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had not acted to develop a culture of respect and inclusion for everyone. Whistle blowers told us that there was a poor culture within the service and a lack of support. After we raised concerns with the provider about the first number of whistle blowing concerns, we received further concerns from whistle blowers alerting us to verbal threats made by some members of the management team about whistle blowing to CQC. This did not create an open and honest culture within the service.

● People and relatives told us they did not know who was running the service. The provider had not communicated with people and relatives regarding staffing changes.

● The provider's statement of purpose detailed that one of the main aims of the service was, 'Our aim is to deliver a quality support service which encourages individuals to attain a high degree of independence. We provide a wide range of support and services which include - education, leisure activities, health and wellbeing advice and much more.' It was clear from the experiences of people receiving a service and our observations that the provider was not always meeting their aims and objectives for the service.

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Only a small amount of people had been given opportunities to provide feedback about the service. Surveys and feedback evidenced that nine people had been surveyed in April 2021. The results had been collated but no action had been taken to address the concerns raised.

● Four relatives had been surveyed in April 2021. One relative had reported a lack of variety of meals and an action was recorded to show this had been reported to the kitchen. However, meals continued to lack variety, and this was consistently fed back by people during the inspection.

● Staff had been surveyed in March 2021. 27 staff had completed and returned surveys. Completed surveys showed that some staff had stated they felt overworked and tired, wanted more training and some staff reported that management were only sometimes approachable. We discussed the surveys with the acting manager to understand what action had been taken to address these concerns. It was not clear what action had been taken, which may have caused the increase in whistle blowing about similar issues to CQC.

The provider had failed to act on feedback from people, staff and their relatives to continually evaluate and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had not been open with people's relatives about management changes at the service. Relatives were concerned about changes to the management team and many were unaware the registered manager had left. They told us, "I hardly know who the manager is. No one introduced the manager"; "I don't know who the manager is now. I talk to the girl in the office, she's good" and "There's been a lot of changes but no feedback. I don't know who the manager is."

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the

service can be informed of our judgments. The provider had displayed a copy of their rating in the main entrance to the service.

Working in partnership with others

- The previous registered manager had worked closely with the health care professionals such as community nurses and people's GP. The acting manager explained that they had contacts within the local authority commissioning team and had continued to build working relationships with local health and social care professionals to support people's changing needs and develop the service.
- The acting manager told us they planned to sign up to other external support agencies to enable them to effectively manage the service such as Skills for Care, local authority manager forums and said they would sign up to the CQC newsletter to ensure they kept up to date with changing guidance.