SA & JO Care Limited

Crouched Friars Residential Home

Inspection report

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Colchester
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Crouched Friars Residential Home is provides personal care for up to 56 people aged 65 and over. It is located close to the centre of Colchester in an older building which has been adapted. The service can support up to 56 people. At the time of our inspection there were 42 people living in the service.

People's experience of using this service and what we found

People were at risk of harm due to the registered manager and provider's failure to identify, assess, manage and mitigate risk. This included putting people at risk of abuse and receiving unsafe care. Risks to people were not always identified appropriate with actions put in place to mitigate the risks.

People were not being supported by sufficient numbers of staff with the right skills that were being deployed effectively.

People's rights were not upheld with the effective use of the Mental Capacity Act 2005. 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. Their needs were
not accurately assessed, understood and communicated.

People's care needs were not effectively identified and recorded. Care provided did not consistently meet people's needs and was person centred. People and their possessions were not treated with dignity and respect by staff or the management team.

The governance of the service was ineffective. There was a lack of accountability on behalf of the provider and a failure to act promptly on identified concerns. This had resulted in people receiving unsafe care that exposed them to the risk of avoidable harm.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 26 February 2019) with a breach of regulation in relation to risk assessment. The service has deteriorated to Inadequate. We have identified breaches of eight regulations under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the management of risk, how care was planned and delivered, staff training and staff numbers, infection control, the condition of the building and garden and the overall leadership of the service.

We are taking enforcement action but cannot yet publish the actions due to the representation and appeals process.

The inspection was prompted in part due to concerns received about staffing levels and the quality of care provided. A decision was made for us to inspect and examine those risks.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Crouched Friars 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.

Inspection team
The inspection was carried out by two inspectors.

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

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

Notice of inspection
This inspection was unannounced.

What we did before inspection
Before our inspection we looked at information that had been sent to us. On this occasion, we had not requested the provider to complete and submit a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. This was because our inspection was carried out at short notice, following information received.

During the inspection
We observed how staff interacted with the people who used the service and how people were supported throughout the days. We spoke with three people, two relatives, the registered manager, the nominated individual and six members of staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of care records This included inspecting six people's care and support records in detail and staff personnel and training records. We also viewed records relating to the management of the service including quality and safety documents, audits, medication records and incident, accident, complaint and safeguarding records.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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.

Systems and processes to safeguard people from the risk of abuse

- Our inspection of July 2018 found that safeguarding systems and processes were not working effectively. The inspection of January 2019 found some improvements. At this inspection we found that the improvements had not been maintained.
- The service did not have established systems and processes to protect people from abuse.
- Body maps in nine care records showed people had developed bruising. This had not been investigated to identify the cause. The registered manager told us that they did not consider it necessary to investigate the cause of the bruising. Lack of investigation into this type of incident could mean that an underlying cause was not identified.
- Where safeguarding issues had been identified and were being investigated, appropriate actions had not been taken to ensure people were protected from further risk of harm. This included notifying the CQC and taking action to ensure people were safe.
- Staff were not able to clearly explain to us what safeguarding people meant. Neither were they able to explain the procedure they would follow if they had concerns.
- Five night staff were shown on the training records. Of these five night staff only one was shown as having received safeguarding training.

Systems and processes did not protect people from the risk of abuse. This is a breach of Regulation 13, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management

- There were no current or recently reviewed risk assessments relating to health and safety, equipment or the environment.
- Where actions had been put in place to minimise risk these were not followed to ensure people were safe. For example, there were alarms at the top and bottom of a stair case. The alarm at the bottom of the stair case was turned off for the duration of both of our inspection visits and the alarm at the top of the stairs was turned off by staff when they were working on the first floor. This allowed people to access the stair way without staff being aware. The service supports people living with dementia who may not appreciate the danger posed by stairs.
- Care records were not always accurate and were confused with regard to the identification and management of risk and did not always reflect what was being carried out by staff. For example, one person had an entry in the daily records which stated they got up at 4am and walked into another person's bedroom, this was contradictory to the risk assessment which stated that they had very limited mobility.

● This person slept on a mattress on the floor. Their care records had not been reviewed to reflect this approach to their care or if it was in their best interests. We were told by the night staff senior they slept on floor following a fall over bed rails. Care records did not record falls from bed. The person had also had been assessed as at high risk of pressure ulcers. Their profiling bed moved up and down and could be lowered to a safe level for a person to roll out onto crash mat on the floor. By sleeping on a mattress on the floor they were not on an airflow mattress to prevent pressure breakdown of skin. How the person was supported to get up off the floor was not addressed in the care records and care staff were unable to explain how this was carried out safely.
● Concerns had been found with moving and handling practice at our last three inspections. At this inspection we observed moving and handling practice at the service which put people at risk of harm. One person was supported to transfer from a wheel chair to a chair using a stand aid. Use of a stand aid requires the person to support some of their body weight with their arms. The person was unable to do this and was in effect dragged from the wheelchair to the chair. As care staff walked away from the person the person was heard to say, "I don't like it. They make me do it."
● Equipment had not been assessed as safe to use. Two people slept on divan beds and had bed rails held in place by the weight of the mattress and the occupant. The mattress was thin and light which meant when the occupant moved there was a risk the bed rails could move posing a risk of entrapment. The bed rails did not meet safety specifications.
● People's personal evacuation plans (PEEPS) did not consider people's emotional, psychological needs, medication they took and how it affected them for example sedation which can affect how people need to be supported or how many staff need to assist them. Some PEEPS said people needed a 'sheet' to help them down the stairs. The registered manager told us that they currently use a 'bag'. Lack of clarity could cause confusion in event of a fire. They did not have an evacuation chair, but the registered manager told us this was on order.
● Staff did not effectively and safely support people who expressed their frustration and anxieties through their behaviours. Positive actions were not planned for or put into practice when staff were faced with difficult situations that could potentially compromise safety.

Preventing and controlling infection
● A recommendation was made in relation to infection control at our last inspection. When we asked the registered manager what they had done in response to the recommendation they declined to tell us.
● There were no sluice facilities or equivalent for the emptying, cleaning and disinfecting of commodes and no cleaning schedule in place for commodes. Staff told us they were washed in people's sinks or the bath. They were unable to demonstrate that commodes had a weekly deep clean to reduce the risk of cross contamination.
● We were shown a cleaning audit with ticks to say what has been cleaned and by who. It showed that walking frames had not been cleaned since June 2019, wheelchairs had not been cleaned since June 2019 and commodes had not been cleaned since June 2019. There was no indication as to whether this cleaning should be carried out daily, weekly or monthly.
● Wall surfaces of the laundry room and around the sink were damaged with peeling paint, and damaged seals around the sink. This did not allow for effective cleaning.
● There were no bed and mattress checking and cleaning schedules in place. We found one person's divan bed and mattress heavily stained and we could feel the springs through the mattress top. This increased the risks to people of cross infection and posed a risk to their skin and physical wellbeing.
● Spare pillows stored in linen cupboards were heavily stained from secretions.
● Communal areas were not consistently clean. We observed cobwebs and spiders in one of the lounges.

● Five night staff were shown on the training records. Of these five night staff only one was shown as having

received infection control training. It was clear that staff were unable to recognise the risks related to poor cleaning and hygiene practices.

Risks were not assessed and managed effectively. Infection control was not effectively managed. This is a continued breach of Regulation 12, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Staffing and recruitment

● There were insufficient numbers of suitable staff deployed to support people safely and ensure their needs were met at key times throughout the day. For example, we were told by one person that they had stomach pain and urgently needed to use the toilet. We immediately told a member of care staff. Fifteen minutes later we spoke to that member of care staff who told us they had not attended to the person who needed the toilet as they had to finish tending to another person.

● There was no effective system to calculate the number of staff required to meet people's needs. Assessments and care plans did not give a correct indication of people's current and changing needs particularly in relation to the wider aspects of their dementia related needs such as social, emotional and psychological needs. The management did not demonstrate a clear understanding of the complexity of people's current needs and level of dependency to ensure an accurate calculation of staffing levels. The complexity and difficulty of the layout of the building was also not considered.

Sufficient staff competent staff were not employed to meet people's needs. This is a breach of Regulation 18, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

● Staff were not recruited safely. For two staff recently recruited to the permanent staff checks had not been carried out into their employment history to ensure they were suitable to work in the care sector. References had been received by email. Reference documents did not contain dates or details of the employer or who was supplying the reference. Another member of care staff had been supplied by an agency and was on their second day working in the service. The manager was unable to supply confirmation that the person had had any pre-employment checks or training to ensure they were suitable to work in the service. The person was unable to converse with us and advised that they could only read, "A bit," of English.

● From our observations of staff practices we concluded they had not received effective training in safety systems, processes and practices.

Appropriate checks were not carried out to ensure staff were suitable to work in the care sector. This is a breach of Regulation 19, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Using medicines safely

● Medicines were stored safely and were audited to ensure they were administered correctly and were accounted for.

● Where people were on medicine which controlled their behaviour, records did not demonstrate that the service ensured its use was not excessive or inappropriate. For example, one person's care plan showed that the service had contacted their GP to request an increase in this type of medicine. There was no record of the behaviour which had prompted this request or any action which had been taken to address the behaviour before the GP was contacted. Since the medicine had been prescribed there was no record to show if it had or had not been effective.

Learning lessons when things go wrong

● There were no arrangements to review and investigate safety and safeguarding incidents and events when things went wrong.
● The service has a track record of failing to provide good standards of safety and has not followed national guidelines in relation to key areas such as health and safety and medicines. There is no recognition of the shortfalls or the risk and therefore lessons have not been learnt.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

At our last inspection we recommended the provider sought advice on promoting people's independence and creating a dementia friendly environment. The provider had not made any improvements.

- The layout and decoration of the home was not conducive to the needs of people living with dementia.
- Our previous inspection had identified a lack of dementia signage and decoration to help support people with visual clues to navigate their way around the building and promote interest. At this inspection we found this had not been addressed and signage and decoration did not support people to move around the building.
- Some bed rooms contained personal items such as photographs and ornaments. However, we observed in the bed rooms of some people living with dementia there were no personal items to remind the person of people and places that were important to them.
- The linen rooms lacked an adequate stock of duvets, duvet covers and pillows. There was not enough bed linen to meet the needs of 46 people with continence needs.
- The garden contained old beds and rubbish waiting to be collected. A shed which was rickety and broken and garden furniture which was old, worn and broken. People had access to the garden and staff told us that people regularly went out into the garden. The poor maintenance of the garden posed a hazard to people's safety.
- The heating and hot water system was not thermostatically controlled to meet people's needs. During our inspection visits we found one part of the building to be excessively hot and sticky whilst another part was cold, and people were covered with blankets to keep warm.
- During our inspection we observed cobwebs and spiders in communal areas. The cleaning schedule did not clearly demonstrate what areas should be cleaned and how they should be cleaned.

The premises were not clean and properly used. This is a breach of Regulation 15, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and equipment.

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

- People were not involved as far as they were able, in their care planning.
- People were at different stages of their dementia ranging from early onset to advanced stages. Care plans did not contain up to date assessments of people's needs. This included their physical and mental needs.

- Care and support delivered did not reflect best practice and did not achieve effective outcomes for

people. Care was not planned or delivered in a way that met their needs and choices and did not consider their social, emotional and psychological needs. Skills in communication, person centred care, diversity and engaging with people in purposeful activity were lacking.

● Information had been taken from the internet and placed into people's care plans. However, the information had not been used to plan people's care and support.

● There were no strategies in place for staff to respond effectively to people's heightened anxiety which resulted in individuals not receiving personal care as and when they needed it. For one person entries in daily records refer to them as 'aggressive' particularly when being assisted with personal care. Care records did not have any information about triggers for the anxieties or any strategies staff must follow to reassure and support him.

The above represents a breach of Regulation 9, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Staff support: induction, training, skills and experience

● People were receiving care and support from staff who did not always have the skills and competency to carry out their role.

● Staff training, development and support was not pro-active or effective to ensure staff had the right knowledge and skills to deliver the right care and support to people living with dementia. This included managing high levels of anxiety and supporting people to have access to meaningful stimulus, tailored to their level of dementia/needs.

● There were no systems or processes in place to provide new staff and temporary (agency) staff with effective induction training, support and continued competency assessment. Newly employed staff confirmed they had not started The Care Certificate; a national recognised programme and assessment to support new staff in gaining an understanding of the fundamentals of care and standards they should be working to.

● During our inspection visits we witnessed poor practice in regard to moving and handling and infection control. This had not been recognised by staff or management.

● The provider did not have a staff member who was sufficiently trained and competent to carry out health and safety responsibilities in the home. Checks in place were not comprehensive or based on nationally recognised health and safety requirements.

The above demonstrates a breach of Regulation 18, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

● Staff told us that they received supervisions which they found useful to discuss any concerns.

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

● People were not supported to maintain a balanced diet and remain hydrated. For example, jugs of juice were put out in the communal lounges, but they were not accessible to most people who did not recognise that they were thirsty or have the mobility to get up and help themselves. This meant they were heavily reliant on staff; staff did not give out cold drinks and so people went without.

● Care plans contained generic nutritional information. However, there was no indication how this information was used to support the individual person.

● For one person their weight had decreased by two kilogrammes between February and March 2019. We were unable to determine if their weight loss had continued as no further weights had been recorded. The care plan did not contain guidance on staff regarding actions to be taken to address the weight loss. This put the person at risk of malnutrition with no action taken to address the issue.

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

● Staff did not work together to provide good quality care and support. We were given examples of action taken by different care shifts if the previous shift had not completed certain actions.

● The service did not follow advice provided by healthcare professionals on supporting people to stay healthy. For example, one person had been seen by the diabetic nurse in May because their blood sugars were very high. The nurse provided advice on a diet. This was not reflected in her care plan.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires 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 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.

● Management and senior staff demonstrated a lack of understanding of the legal framework, relevant consent and decision-making requirements of the MCA 2005 and associated best interest decisions.

● Records showed best interest decisions had been made for people who had the mental capacity to make decisions for themselves.

● Where best interest decisions had been made for people who lacked capacity there was no record to show other methods had been considered and tried to as far as possible support the person to make their own decision.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion or dignity; staff did not always demonstrate caring attitudes.

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

- The provider and registered manager had not ensured the service was run in a manner that promoted a caring and respectful culture. There were significant shortfalls as shown throughout this report about the standard of furnishings and the poor upkeep of the home. There was a failure to recognise the importance for people to have a clean, comfortable and warm bed to support their wellbeing and dignity.

- People were left in an unhygienic and undignified manner because staff did not know how to support them. Respectful, compassionate and emotional support was not consistently delivered where needed. We observed one person in a wet bed in a cold room. Staff were unable to tell us how they could deliver care and support to ensure they were warm and comfortable.
- The registered manager had not encouraged a culture to support staff efforts alongside appropriate knowledge and resources, to help staff understand the needs of people and how they should be cared for.

- The provider and registered manager had not ensured there were sufficient staff on duty so that they had the time to deliver care with kindness and compassion. There was a culture on the delivery of task-based care.
- Care plans did not contain details of people's personal history. This is particularly important where people live with dementia to allow staff to converse in a meaningful manner and provide distraction if required.

Respecting and promoting people's privacy, dignity and independence

- People's dignity and independence was not promoted or respected.
- Staff did not always refer to people in a respectful way and regularly used people's room numbers when referring to the person.
- People were not always addressed in a caring and respectful manner. Staff held conversations across people whilst providing care and support which did not support people's dignity. In one example the registered manager shouted to a person across their bed room.
- Mattresses, bed linen and pillows had been allowed to deteriorate into a very unhygienic state.
- The service was responsible for washing people's clothing. This was not treated respectfully. Whilst clothing was waiting to be taken to people's bed rooms it was stored in boxed shelving unfolded and, in some cases, partly hanging out of the storage box.
- Care records were not stored securely. They were kept in unlocked cabinets in an unlocked room which we observed was regularly left unattended.

Care was not provided in a manner which maintained people's dignity and ensured they were respected.

This is a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and Respect.

Supporting people to express their views and be involved in making decisions about their care

- People were not supported to express their views or make decisions about their care and support.
- There was a culture in the service of delivering care in a way which best suited the organisation and not how people preferred. For example, getting people up very early in the morning despite their choice and preference. Our first inspection visit took place at 5.30 in the morning. We found four people were up and dressed. Their care plans made no reference to this being their preferred time to get up in the morning. The relatives of one person who was up told us that the person liked lie in in the mornings.
- Night staff had prepared individual breakfast trays for each person. Cereal bowls had been pre-prepared. Toast was made and left on trays for an extended period of time, meaning it was cold when taken to people's rooms. There was a printed card on each tray stating what the individual had for breakfast – it was the same each day. When they were handed out people were not asked if they would prefer anything else. Staff told us breakfasts had always been prepared like this. They were unable to tell us when the printed card had been reviewed.
- Care plans did not demonstrate that people had been involved in there writing or review as far as they were able.

Inadequate

Is the service responsive?

Our findings

Is the service responsive?
Our findings
Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we recommended the provider reviewed and updated care plans to reflect people's needs and provide clear guidance to staff on how to support people. This had not been done.

- Care and support was not planned and delivered in an individualised or personalised way. People or care staff were not part of the care planning process.
- Care records contained generic information which had been printed from the internet, but which had not been used to develop individual care plans.
- Significant and relevant information about people's background and life stories was not gathered and utilised to inform their care plans and to guide staff on how to support the person in the most effective way.
- Care and support plans did not reflect the abilities and strength of individuals or how their dementia related, mental health or long-term health conditions impacted on their day to day living. They did not inform staff about the type and level of support each person needed to meet their specific needs, promote their wellbeing and enable them to lead fulfilled and meaningful lives. Nor did they include information in relation to triggers, understanding and personalised support needed by people who at times presented distressed behaviour or behaviour that was challenging to others.
- Where people lived with dementia their history and preferences had not been recorded and were not taken into account when care was delivered. For example, we spoke with the relatives of one of the people up and dressed when we visited at 5.30am. We asked if the person had liked to rise early before they moved into the service. They told us that the person liked to lie in bed and did not like to get up early. Staff told us that the person had chosen to get up early. Care records did not record their preferences.

- Activity provision was not regular or at a level which met the individual and specific needs of people using the service. We observed people spending long periods disengaged or asleep in their chair.

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 had not been considered in the care planning process.
● One person's care plan stated that they had poor eyesight and hearing. There was no information in the care plan as to how this person was supported with their communication needs.

Supporting people to develop and maintain relationships to avoid social isolation
● People were not always supported to take part in activities that were socially and culturally relevant to them.
● Care plans did not contain details of people's social interests or hobbies so that the service could support them to follow these.
● The activities co-ordinator was annual leave during both of our inspection visits. Nothing had been done to ensure the role was filled during their absence. We observed staff trying to provide activities, but they displayed a lack of knowledge of how to do this effectively for people living with dementia.
● Visiting relatives told us they were free to visit the service when they wished.

People were not involved in the care planning process and care was not delivered in accordance with people's preferences. People's communication needs, and social engagement was not being met. This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Improving care quality in response to complaints or concerns
● The registered manager was not open to complaints and did not manage the complaints process effectively. They were not pro-active in investigating complaints or concerns raised by staff and there was no evidence of applied learning.
● The complaints policy was not displayed in the service and accessible to people.

End of life care and support
● There was no recognition that a diagnosis of dementia or Alzheimer's is a terminal disease.
● Staff had not received training in end of life care.
● End of life was not planned for to enable staff to be responsive to a person's preferred care and support needs and wishes.

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 Requires Improvement. At this inspection this key question had deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. The leadership of the service 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

At our inspection in July 2018 we found governance and oversight were not effective and there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2004. At our inspection in January 2019 we made a recommendation that the service seek advice on developing audits to measure quality and identify shortfalls. This had not been done.

●The provider was out of touch of what was happening in the service. We were told that they visited the service weekly but did not carry out any effective audits or quality assurance processes. They were unaware of the heating issues in the service.
● Our previous inspection report in January 2019 detailed a breach of regulation and made five recommendations. At this inspection we found the service was still in breach of the same regulation and had not acted on any of our recommendations.
● The provider had no overall vision for the improvement and development of the service.
● The provider and registered manager were unaware of their responsibility to ensure staff working in the service were suitable for their role. Lack of oversight had resulted in a person working in the service who may not have had full background checks.
● The registered manager and provider had failed to consistently report certain incidents to the relevant authority such as CQC and the local authority safeguarding team.
● Staff were not recognising or managing risks. This was compounded by the lack of up to date, relevant and personalised risk assessments and care plans for people to guide staff on how to deliver proper and safe care.

Continuous learning and improving care
● The provider's governance systems and processes were ineffective and did not identify shortfalls in the operation of the service. The provider and management had not pro-actively found where quality and safety were compromised and respond appropriately.
● The provider and registered manager did not understand the principles of auditing and how results of audits informed the quality monitoring and assurance cycle. Audits provided were no more than records of data; there was no robust analysis of the information to identify the strengths and weaknesses of the service. Trends, themes or root causes were not looked for.

● The provider had no systems in place to check if people's life and experiences of living in the home could be improved upon in any way.

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

● Staff were unclear of their roles and responsibilities and there was no structure or direction for the staff team. They were not provided with proper training or guidance to enable them to effectively carry out their role.

● Some staff did not feel listened to and gave examples of when they had taken concerns to the registered manager, but these concerns had not been taken seriously but dismissed as not relevant.

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 service did not have a policy of on its responsibilities under the duty of candour.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The culture of the service was not open, transparent or inclusive. Staff told us they felt devalued; there was no positive engagement from the provider, only a blame culture.

● There was no engagement with other organisations, agencies or networks to share best practice, expertise or resources to improve the service and deliver a good experience of care for people.

The service did not have systems, processes or leadership in place to operate effectively. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2004.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and choices were not assessed and care was not delivered in line with current guidance. People were not involved in the care planning process and care was not delivered in accordance with people's preferences. People's communication needs, and social engagement was not being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care was not provided in a manner which maintained people's dignity and ensured they were respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not assessed and managed effectively. Infection control was not effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes did not protect people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not clean and properly used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have systems, processes or leadership in place to operate effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Appropriate checks were not carried out to ensure staff were suitable to work in the care sector.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient staff competent staff were not employed to meet people's needs. Staff did not receive appropriate training and supervision.