APPENDIX

Oakray Care (Fairview) Limited

Fairview House

Inspection report

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Date of inspection visit:
02 November 2017
06 November 2017
30 November 2017

Date of publication:
08 January 2018

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

Fairview House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for 24 people. There were 22 people living at the home at the start of the inspection.

People are accommodated on two floors, with a third floor providing office accommodation. Six rooms had en-suite bathrooms. In addition, two larger bathrooms and a wet room were provided, together two lounges and a dining room.

The inspection was unannounced and was conducted on 2, 6 and 30 November 2017. It was the first inspection of the service since the provider took over the operation of the home on 30 June 2017.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager resigned between the second and third days of the inspection, with immediate effect. However, they remain legally accountable for the service at the time of the inspection and going forward until they have deregistered with CQC. The provider responded by bringing in a manager from one of their neighbouring homes to provide management cover.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

There were widespread and systemic failings identified during this inspection. The provider had failed to establish and implement clear working practices, policies, procedures or quality assurance systems. They acknowledged that they had no effective oversight of the service. Quality assurance systems were not robust. Where deficiencies had been identified, they had failed to take action to address these. For example, they had failed to address hazards identified in a fire safety risk assessment; and they had failed to ensure staff received appropriate training (having cancelled training that had been planned).

Not all staff were caring and compassionate. Some demonstrated a lack of respect for people and their property and did not treat people with consideration. Two people were not dressed appropriately to protect their dignity; and people were sometimes given other people's clothes to wear.

We found significant concerns relating to health, safety and welfare of people. There were not enough staff to keep people safe and meet their needs and the situation deteriorated during the course of the inspection when the registered manager, a cook, a cleaner and several care staff resigned.

Areas of the home were not clean and infection control arrangements were inadequate. We found puddles of urine in two people's rooms; beds and bedding covered in dried urine and faeces; and wet beds that had been made up for people to use. Laundry was backed up in the laundry, people's commodes were not emptied or cleaned effectively and clinical waste was not managed safely.

We referred concerns relating to the cleanliness of the kitchen to the Environmental Health department of the local authority and they took action using their own powers.

Individual risks to people were not managed effectively. Pressure-relieving mattresses were not set correctly; a slide sheet was not available to support a person to reposition; a person was dressed in trousers that were too long and presented a trip hazard; staff did not have access to information or guidance about head injury monitoring; and not all staff had received fire safety training.

There was not a gas safety certificate in place and a subsequent check by a gas engineer revealed that the gas cooker was not safe and should not be used. As a result, staff were unable to prepare a choice of adequate meals for people.

Medicines were not managed safely. People did not always receive their medicines as prescribed, including antibiotics for chest infections. Two people were subsequently admitted to hospital with suspected chest infections. A further person did not receive an essential blood-thinning medicine on nine occasions. In addition, best practice guidance was not followed in respect of administration and recording practices.

Systems and processes used to investigate abuse or allegations of abuse were not operated effectively. We identified two instances where concerns met the threshold for reporting to the local authority, but this had not been done. During the course of the inspection, other allegations of potential abuse were identified by senior staff and were reported as required. These allegations have now been referred to the police.

Staff did not follow legislation designed to protect people's rights. Conditions applied to authorisations to restrict people's liberty were not followed and staff did not know which people were subject to restrictions.

We found staff had not received appropriate training for their role. Some staff had not completed moving and handling training, yet were using equipment to support people to move. Others were not up to date

with essential training, including in subjects such as safeguarding, infection control and food hygiene.

Staff supported people to eat, but this was not always done in a safe or dignified way. People did not always have access to drinks and some staff did not know how to thicken drinks to an appropriate consistency to protect the person from choking. Although staff monitored people's weights, action was not taken when one person lost a significant amount of weight.

Some adaptations had been made to create a supportive environment for people, but noise levels were sometimes excessive and the layout of the building created a bottleneck that prevented the free flow of people around the home.

People were usually supported to access healthcare, although we identified occasions when staff had failed to identify that people needed extra support or medical intervention.

Staff were not responsive to people's needs and people did not always receive the care and support they needed. Some people appeared dishevelled and were not supported with their personal and oral care. People were left in uncomfortable chairs for extended periods.

People's care plans had been developed with input from the person and their family members, but people were not consulted about all aspects of their care. Care plans encouraged staff to promote people's independence, but had not been updated to reflect people's current needs and were not being followed.

People were not supported to lead active lives through the provision of meaningful activities. The provider had cancelled some pre-planned activities and staff told us they did not have time to organise activities for people.

Record keeping practices were not adequate. Staff were disorganised and were not given clear direction, although they said they felt supported by the registered manager.

The registered manager told us they had not received any complaints, although feedback from the local authority indicated that family members had raised concerns with other staff. We identified that the provider did not have a complaints procedure in place. This was developed during the course of the inspection, although it was not communicated to people or their families.

Appropriate recruitment procedures were in place and followed. The registered manager had complied with the duty of candour requirements by notifying family members verbally and in writing when people had come to harm.

Some staff had received training in end of life care and people's end of life wishes were recorded. A family member provided positive feedback about the end of life care provided to their relative.

After the first two days of the inspection we wrote to the provider detailing our concerns. On the third day of the inspection we found that action had not been taken and the care and support afforded to people had deteriorated. Due to the level of concerns we identified, we used our urgent powers to prevent any new admissions to the home. We are also considering what other regulatory action to take.

We liaised with the local authority who commission services at the home. As a result of these discussions, and due to the fact that the safety of people could not be assured, people were moved to alternative homes that could meet their assessed needs. The provider acknowledged that they had found the situation

"challenging" and had also asked the local authority to consider moving some people out of Fairview House.

We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about the commission's regulatory response to the breaches will be added to the report after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff deployed to meet people's needs and staffing arrangements were not robust.

Areas of the home were not clean and infection control arrangements were not adequate. Some people's beds were wet from urine and dried faeces.

Risks to the health and safety of people were not managed effectively, which put people at risk of harm. Staff fire safety training was out of date and deficiencies identified by a fire safety risk assessment had not been addressed. A gas safety certificate was not in place and the home's gas cooker not safe to use.

Medicines were not managed safely and people did not always receive their medicines as prescribed. Systems and processes used to investigate abuse or allegations of abuse were not always operated effectively.

Appropriate recruitment procedures were in place and followed.

Is the service effective?

Inadequate

The service was not effective.

Staff did not follow legislation designed to protect people's rights and freedom.

Staff did not receive adequate training to enable them to support people safely or effectively.

Staff did not always provide appropriate support to ensure people ate and drank enough or in a safe way.

Some adaptations had been made to make the building supportive of people's needs. However, noise levels were excessive and the layout of the building caused a bottleneck that prevented the free movement of people.

People were usually supported to access healthcare services and arrangements were in place to share information about people with other care providers.

Is the service caring?

Inadequate

The service was not caring.

Some staff did not treat people with dignity or respect or show consideration for people's property.

Confidential information was not always kept securely.

Care plans had been developed with input from the person and their family members, where appropriate. However, people were not consulted about all aspects of their care and the care plans were not always followed.

Care plans encouraged staff to promote independence.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive the care and support they needed. Some people were not supported with personal care tasks and staff were unable to recognise when people needed additional support.

Care plans had been developed, but these had not been reviewed recently and did not always reflect people's current needs.

People were not supported to lead active lives as meaningful activities were not provided.

People had mixed views about whether they were empowered to make day to day choices.

The provider updated their complaints policy during the course of the inspection, but had not circulated this to people and their families.

Some staff had received training in end of life care and people's end of life wishes were recorded.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to establish and implement clear working practices, policies or procedures.

There was no oversight of the service by the provider. Audits conducted by the registered manager and other staff were not robust. They had not identified or addressed any of the concerns we identified.

Record keeping practices were inadequate. Staff were disorganised and there was a lack of resilience in the management team.

Staff felt supported by the registered manager, who acted in an open way when people came to harm.

Fairview House

Detailed findings

Background to this inspection

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

This inspection took place on 2, 6 and 30 November 2017 and was unannounced. It was conducted by two inspectors on 2 and 30 November 201 and three inspectors on 6 November 2017. The inspection was prompted by information of concern about the standard of care being provided and the environment in which people were living.

This was the first inspection since the provider took over the operation of the service on 30 June 2017. Before the inspection, we reviewed information that we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

During the inspection, we spoke with five people living at the home and four visiting family members. We were unable to speak with other people because of their level of cognitive impairment. We spoke with the provider's nominated individual; this was a director of the provider's company who had been nominated as the point of contact with CQC. We also spoke with the provider's compliance manager, the registered manager, a covering manager from another home operated by the provider, nine care staff, a cleaner, an administrator, a maintenance person and a cook. We looked at care plans and associated records for 12 people, staff duty records, recruitment files, cleaning records, records of complaints, accident and incident records, and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with a community nurse who had regular contact with the home and received feedback from managers and social care practitioners from the local authority's safeguarding and commissioning teams. We looked at care plans and associated records for 12 people, staff duty records, recruitment files, cleaning

records, records of complaints, accident and incident records, and quality assurance records. We also received feedback from the Clinical Commissioning Group (CCG) Medicines Management team, who conducted a review of medicines management in the home between the second and third days of the inspection.

Inadequate

Is the service safe?

Our findings

There were not always enough staff deployed to meet people's needs and keep them safe. One person told us, "I have to wait so long for the toilet. You call out, but it doesn't work. It's an awful job to get hold of [staff]. I dread that as I never know how long it will take. I always get told 'You'll have to wait'." A family member told us, "I think they should have more staff. There's not enough of them."

The registered manager told us staffing levels were based on people's needs. They said five care staff were required in the morning, four in the afternoon/evening and three during the night. However, duty records for the three weeks prior to the inspection showed these staffing levels had not been achieved on 13 morning shifts and seven night shifts. On the night shifts, this meant there were only two staff to support the 22 people living at the home, 12 of whom needed the support of two staff for some aspects of their care. In addition, night staff were required to clean and do the laundry. A staff member told us, "The laundry gets backed up in the morning as the night staff can't get everything." Another staff member said, "There are not enough staff. People don't get [the support] they should; people need more." A further staff member described feeling "run ragged" because of the extra hours they were having to work to cover staff shortages.

Our observations confirmed that there were not always enough staff to support people in a timely way. One person waited 12 minutes before a staff member was able to support them to use the bathroom. They were clearly unhappy and distressed by the wait. They became visibly anxious, shuffling in their seat and trying to self-mobilise without their walking frame. On another occasion, we observed a person living with dementia drinking from other people's cups. They then moved a large floor fan from behind a door and tried to switch it on before leaving it in people's way. Staff were too busy to notice this and the fan was not removed for a further 10 minutes. The lack of staff left people at risk.

Staff did not have time to spend with a new person, who we saw became unsettled and agitated on their first day in the unfamiliar environment. A staff member later told us, "It's the first time [the person] has been here and we've got no time to spend with them." Another staff member told us they were expected to do too many tasks; they said, "I do care, activity co-ordinator, kitchen, laundry and cleaning. It's too much."

Between the second and third days of the inspection, the registered manager, a cook, a cleaner and several care staff members left the service. A manager and some care staff from one of the provider's neighbouring homes were brought in to provide cover, together with agency staff. However, they were not familiar with the people living at Fairview House and were not always able to provide effective support. In addition, we found the staffing arrangements were not robust. Managers were having to plan on a shift by shift basis and were struggling to find enough staff to cover; for example, at 6pm one evening, they had still not arranged enough staff for the following morning.

The failure to ensure enough competent, skilled and experienced staff were deployed to meet people's individual needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control procedures were no adequate and put people at risk of harm. On the morning of the first day of the inspection, the home smelt of urine and we found puddles of urine on the floors of two people's rooms. These were still there an hour later, when we drew them to the attention of the registered manager. A mattress in another room was soaked with urine and was drying against a wall; later in the day, we checked the room and found the mattress had been put back on the person's bed and made ready to use. The mattress was still wet and smelt of urine. Two other mattresses, on other people's beds, had dried faeces on them and smelt of urine. On the first two days of the inspection, we found toilets and toilet seats were not clean; for example, one had a large amount of dried faeces around the rim and remained in that state all day.

People's commodes were not emptied or cleaned effectively. One person's commode was left full for several hours and another person's commode still contained some urine after we were told it had been cleaned. The registered manager told us people's bed sheets should be changed daily, but our observations showed this was not happening; some were stained with dried faeces, smelt of urine and were badly creased.

Clinical waste was not managed safely. Bags containing used continence pads were left on one person's chest of drawers and in one of the bathrooms. The bags were not secure and urine was leaking through them. The lid and foot pedal of a clinical waste bin were broken, so staff had to handle the lid to place waste in it. These issues posed a risk of cross infection. The flooring in one of the toilets was ill-fitting and badly stained. The gaps around the edges created traps where bacteria could breed.

The laundry room was cluttered and untidy on all three days of the inspection. All the laundry bins were full of washing waiting to be cleaned. Shelves used to store people's clothes prior to being put back in their rooms were falling down. Packets of new sheets and pillowcases were on the floor in front of the hand washing sink, so were at risk of cross infection. They also made it difficult for staff to access the sink and the disposable aprons stored in a cupboard beneath it. One staff member told us they had used the staff washroom to clean their hands after handing soiled linen in the laundry; this was at the other end of the building and meant they would have had to pass through the dining room. This would have posed a risk of cross infection if they had touched any surfaces, door handles or people en route.

On the third day of the inspection, we were advised that a lot of people had chest infections, two of whom had been admitted to hospital for treatment. Despite this risk, we observed a staff member was working when they were clearly unwell. They could barely speak and coughed repeatedly around people, including when supporting them to eat. Later in the day they were sent home, but only after they had had close contact with most of the people living at the home.

Some people needed to use a hoist to transfer between their bed, their chair and their toilet. Hoist slings should be allocated individually and not shared between people to prevent the risk of cross contamination. We could not be assured that this was the case as we found three slings in the bottom of one person's wardrobe and no slings in another person's room. There was no clear process in place to ensure slings were allocated and used on an individual basis.

The kitchen was not clean. We saw old food sitting in a gap between the kitchen cupboards and the floor which posed an infection risk. Following the inspection, we made a referral to the Environmental Health Department of the local authority, who subsequently visited and took action using their own powers. Records showed that 16 of the 22 staff members had not completed or refreshed their infection control training in the previous year, in accordance with the provider's policy.

Other risks to the safety and welfare of people were also not managed effectively. Three people had been

given special pressure relieving mattresses to help reduce the risk of developing pressure injuries. We found two of these mattresses were not set correctly according to the person's weight. Two other mattresses had the wrong type of sheet on them; they were valance sheets, designed to fit under the mattress to cover the base of the bed. They were badly creased with areas of hard stitching across the centre of the bed; this would be uncomfortable for the person and increase the likelihood of them developing pressure ulcers. A third mattress had been made with a sheet that was too small; it kept popping off the corners, creating creases and exposing the mattress.

One person's care plan specified the need for a slide sheet to be used to support the person to reposition in bed; however, staff were not able to find a slide sheet and one was not kept in the person's room. This meant staff would have had to use other, less safe, means to support the person to reposition that put themselves and the person at risk of injury.

We saw one person walking independently around the home. They were wearing trousers that were very baggy and too long for them; they extended beyond the end of their feet, creating a clear trip hazard. The person's care plan stated they were at high risk of falling and directed staff to "ensure suitable clothing and footwear are worn at all times". Staff had failed to do this, which put the person at increased risk of falling. Although we identified this risk to staff on the first day of the inspection, we saw the person continued to wear these trousers on the following two days of our inspection.

Another person was at risk of falling in their bedroom. A sensor mat had been provided to alert staff when the person moved to an unsafe position. However, when we visited the person, we found this was not plugged in and was not in the correct position. If the person had got out of bed without support, staff would not have been aware; this put the person at risk of harm.

On the third day of the inspection, a person fell and sustained a deep laceration to their head. Staff contacted the 111 service for advice and were asked to conduct observations until such time as an ambulance arrived. The home did not have any information or guidance about head injury monitoring, so the covering manager requested this from one of the provider's neighbouring homes. It was clear that staff had not previously monitored people after head injuries and did not know what signs to look for.

The registered manager told us they conducted a monthly analysis of falls across the home to identify patterns or trends; however, we saw this analysis was out of date as it had not been completed for the previous two months. The registered manager attributed this to staff shortages.

Fire safety arrangements were inadequate. We noted that staff training in fire safety was out of date and only four staff members had completed or refreshed their fire safety training in the previous year. Therefore, we could not be assured that all staff had the necessary skills and knowledge to keep people safe in the event of a fire. In addition, a fire safety risk assessment, completed in September 2017 by a fire safety consultant, had identified 78 "significant hazards", including ill-fitting fire doors and door closures. 58 of the hazards were designated as "high priority", but action was not taken to rectify them until we raised the concern during the inspection. The provider then asked a contractor to set out an action plan for the works.

We identified that the home did not have a current gas safety certificate to confirm the safety of the gas boilers and the gas cooker. In response to concerns about the safety of the cooker, a gas engineer was called to check it; they found it was not safe and directed that it should not be used. The defects put staff and people using the service at risk of serious harm.

Medicines were not always managed safely. On the first and second days of the inspection, we observed that

medicines were being managed appropriately. People were supported to receive their medicines as prescribed by trained staff whose competence had been checked by the registered manager. However, on the third day of the inspection, we identified significant concerns.

One person had been prescribed a reducing dose of a medicine for a chest complaint, but this had not been given for a period of 15 days. They were also prescribed an inhaler. Although the medication administration record (MAR) showed the person had received this regularly, the quantity left in it showed they could not have received it as frequently as recorded. The person was subsequently admitted to hospital with a suspected chest infection.

Another person had a chest infection and was prescribed a liquid antibiotic to be taken over a period of seven days. Their MAR chart showed they had received this over a period of 20 days, which was not possible given the quantity of medicine supplied. Either staff had not given the person the correct dose each day, or they had continued to sign the MAR chart when the medicine had been finished. This person was subsequently admitted to hospital with dehydration and a chest infection.

A third person was prescribed a blood thinning medicine. Although the MAR chart showed they had received all necessary doses, the quantity of tablets in stock did not tally with this. We found additional tablets indicating that the person had missed nine doses of this essential medicine. This put them at risk of developing a blood clot.

Other concerns included unexplained gaps in people's MAR charts; 10 sleeping tablets that had gone missing; 'as required' (PRN) sedatives being administered without explanation; insufficient gaps between the administration of paracetamol; staff using abbreviations, G for 'given' or N for 'not given' on MAR charts rather than their signatures, which would make it difficult to follow up potential errors; and hand-written entries on the MAR charts were not always checked by two trained staff members to ensure they were accurate. This was contrary to best practice guidance.

Between the second and third days of the inspection, the medicines management team from the Clinical Commissioning Group (CCG) conducted a review of medicines management at the home, following concerns raised by a visiting social care practitioner. This also showed significant inadequacies in the way medicines were managed, administered and recorded by staff.

The failure to prevent and control the risk of infection, the failure to assess and mitigate risks to people's health and safety, and the failure to manage medicines safely were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes used to investigate abuse or allegations of abuse were not always operated effectively. Staff told us they knew how to identify, prevent and report abuse and gave examples of the signs they would look for, including unexplained bruising. For example, one staff member said, "If I had any safeguarding concerns, I would go straight to the manager and do an incident form." However, we found managers did not always take appropriate action when safeguarding concerns were raised by staff. The care records for one person showed a staff member had raised a concern about another staff member being "rough with the towel" when supporting a person with personal care. The records included a comment from one of the managers about the incident, but the incident was not investigated or reported to the local safeguarding authority. Another person had returned to the home having received treatment in another care setting. Staff had completed body maps showing 14 separate, unexplained bruises found on their return. This was noted by one of the managers, but enquiries were not made to establish the cause of the bruises and the concern was not reported to the local safeguarding authority. When we raised these incidents with

the registered manager, they acknowledged that further action should have been taken. Staff training records showed only two of the 22 staff employed were up to date with their safeguarding training.

The failure to operate effective systems to investigate and report potential abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, five other safeguarding concerns, identified by a covering manager between the second and third days of the inspection were reported immediately to the local authority and to CQC.

Appropriate recruitment procedures were in place and followed. These included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Inadequate

Is the service effective?

Our findings

The provider had failed to ensure that people's rights and liberty were protected. 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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found staff were not working within the principles of the MCA and were not complying with conditions that had been applied to DoLS authorisations.

One person had a condition requiring staff to seek advice from an occupational therapist at the Memory Service, but this had not been done. Another person had a condition requiring them to be given access to the garden, and for this to be written into their care plan so the activity could be monitored. This had not been done and there was no record to show the person had been supported to access the garden. A second condition required this person to be offered regular outings, escorted by staff, but this also was not being met.

The doors of the home were kept locked and people's movements were monitored and supervised by staff at all times, including through the use of a CCTV system in communal areas. When we spoke with staff, none of them knew which people were subject to DoLS and which people were not. People's care plans did not contain up to date information about DoLS applications, authorisations or conditions; this information was only available to the registered manager and was kept in their office. DoLS authorisations usually expire after 12 months, after which they have to be reviewed. The registered manager told us they had reviewed the DoLS authorisations for three people, all of which had expired and needed to be renewed; however, we found they had only submitted a renewal application for one of these people.

The care plan for another person showed they had capacity to make decisions about all aspects of their care. This was confirmed by the registered manager. However, we saw the person's care plan included a risk assessment for 'At risk of leaving the building'. The control measures recorded amounted to continuous supervision and control which the person had not agreed to. Had staff followed these measures, they would have amounted to an unlawful deprivation of the person's liberty. We discussed this with the registered manager who removed the risk assessment from the person's care plan.

The failure to ensure people were not deprived of their liberty without lawful authority was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The MCA also 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Staff described how they sought verbal consent from people before providing care and support and said they were led by the person and acted in the person's best interests. People's care plans included best

interests decisions for all key aspects of their care. However, for one person, these had not been preceded by MCA assessments of the person's capacity to make the decisions, so the provider was unable to confirm that the person was unable to make the decisions. The best interests forms being used by staff included a standard sentence saying that the person's family "were aware and had been involved" in the decision; however, they did not specify which family members had been consulted or what their views were. Staff told us that one person had "fluctuating capacity" to make decisions, but their care plan did not confirm this and there was no record to show that they had agreed to receive the care and support being provided. We discussed this with the registered manager, who told us they would prepare a consent form for the person to sign.

Most family members were satisfied with the care and support their relatives received. For example, one told us, "Staff are superb. [My relative] has made really good progress since moving here. They're smiling now." Another family member told us, "I saw [a person] get aggressive and staff were brilliant."

However, we found staff did not receive appropriate training to enable them to support people safely or effectively. From our observations and from talking with staff, we identified they lacked knowledge, or did not follow best practice guidance, in relation to infection control, DoLS, dignity and respect.

The provider's training records showed that staff, including new staff, had not received adequate training since the provider took over the operation of the service on 30 June 2017. Apart from a brief induction, new staff members had not received training in essential subjects such as moving and handling, safeguarding, DoLS and infection control. These staff members were expected to use moving and handling techniques, including equipment such as slide sheets and a hoist. They were also required to prepare meals for people, but had not received food hygiene training. Their lack of training put them and people at risk of harm. Of the remaining 20 staff, 10 needed to refresh their moving and handling training, 12 needed to refresh their food hygiene training, 19 needed to refresh their DoLS training and 17 needed to refresh their first aid training. One person was receiving their drinks via a syringe, but staff told us they had not received any training to do this safely. Using a syringe for this purpose can put the person at risk of choking and aspiration if not done correctly.

A staff member told us, "We're waiting to be set up with online training. I feel I [particularly] need a refresher in first aid." During the inspection, staff were enrolled onto e-learning courses, so they could start to refresh their training and the provider's compliance manager set a date to deliver practical moving and handling training. The lack of training put people at risk of receiving unsafe or inappropriate care and support.

The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported by the registered manager, who they described as "approachable". They received occasional one-to-one sessions of supervision where they could discuss their progress and any concerns.

Staff supported people to eat, but this was not always done in a safe or appropriate way. We observed a staff member supporting a person to eat who was laid back in a chair. This put them at risk of choking. We asked a senior staff member to intervene and the person was hoisted into a safer position. This took around ten minutes to complete and the person's food would have been cold; however, the staff member continued to give it to the person.

Some people needed to have their drinks thickened to prevent them choking. Whilst some staff knew the

consistency required, others did not and we observed one person being given a drink that was not correctly thickened. This put them at risk of harm. A range of drinks and drinking vessels was available to people on the first two days of the inspection. However, on the third day, we observed that some people in the lounge did not have access to drinks and at lunchtime, we observed that most people were not offered a drink with their meal. As most people were living with dementia, they lacked the capacity to ask for one themselves. In addition, a person being cared for in bed due to a chest infection did not have access to a drink; at 12:15, they told us they had only had one cup of tea all day. We asked staff to bring the person a cup of coffee and a jug of water, which they had requested.

Most people's dietary needs were met and we heard staff offering people a choice of meals on the first two days of the inspection. One person said of the food, "It's all very good, it's nice. There is too much to eat." A family member told us, "The food is very good. I was offered two choices to have today." We observed that when people did not eat their meals, they were offered an alternative, such as a sandwich. However, on the third day of the inspection, we found the home's cooker had been declared unsafe and could not be used. Instead, staff had made a casserole using a slow-cooker. This meant people were not given a choice. One person required gluten free food, but on the third day of the inspection received a dessert that was not gluten free.

Staff monitored people's weight. However, we noted one person had lost a significant amount of weight and no action had been taken. Advice had not been sought from the person's GP or a specialist and their diet had not been reviewed or fortified with extra calories. We discussed this with the registered manager, who agreed to review the person's dietary needs.

The failure to ensure people's needs were met in an appropriate way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had some adaptations to help make it supportive of people living with dementia and people with reduced mobility. A passenger lift had been provided to allow people to access both floors of the home. Handrails had been installed in some corridors. Signs were used to help people find the bathrooms and communal rooms. A wet room had been created to allow people level access to a shower and a large bathroom enabled staff to support people who needed to use a hoist to get in and out of the bath. However, we observed the emergency cords in one bathroom and two toilets were too short, finishing half way up the walls. If a person had fallen onto the floor, they would not have been able reach the cord to call for help. In one person's room, we saw their commode only had one arm support on it; this would have made it difficult for them to get up and put them at risk of falling. The commode did not have a lid on it, which would also have compromised the person's dignity when used.

The layout of the building was not conducive to the free movement of people. It created a bottleneck for people at the entrance to the dining room from the main corridor. The bathroom that most people were encouraged to use was just outside the dining room and we saw staff often waited outside until the person was ready. Other people would also wait outside until it was free. At the same time, people were trying to navigate their way along the corridor to and from their rooms. At one point, a person tried to close the door between the corridor and the dining room and became involved in an argument with staff about whether it should be opened or closed. This additional activity made the bottleneck worse.

There were enough chairs for people in the lounges, but these were all of a similar design and did not suit everyone's needs; for example, one person repeatedly slid out of these chairs and would have benefitted from a reclining chair. Although the television was on for extended periods during the inspection, most people could not see it properly due to the way the chairs were arranged.

We found the noise levels in the main lounge/dining room were not conducive to a calm, relaxing atmosphere for people. Music was being played loudly on the first two mornings of the inspection and staff had to shout to make themselves heard. Overall, it created an environment that was over-stimulating some people, including those living with dementia who are particular sensitive to noise stimulus. We saw signs of this with one person who became visibly anxious.

People were usually supported to access healthcare services when needed. A family member told us, "[Staff] would call a GP if needed. They keep me informed." A community nurse who had regular contact with the home told us they found staff were "helpful" and they had no concerns about the care people received. However, between the second and third day of the inspection, we identified that people's medical needs were not being identified effectively and referrals to healthcare professionals were not made promptly. We have provided more information about this in the Responsive section of this report.

When people transferred to hospital or to another care setting, staff completed a form to record all of the medicines the person was taking. This form then accompanied them, together with their current medicines to help ensure they continued to receive them at their new setting. In addition, staff used a prepared 'hospital administration form' to document people's care and support needs.

Inadequate

Is the service caring?

Our findings

We received mixed views from people about the attitude of staff. One person said of the staff, "They are very kind here; they are all very nice." However, another told us, "Some staff are nice and some aren't. They shout at you. They're moody. And they're rough when they [help me undress]. It's very uncomfortable. It makes me feel awful. I think they are impatient, but they're always telling me I should have more patience; they remind you of it all the time." A further person said, "Staff don't want to help you; they just hurry you along."

Our observations showed that while some staff were kind and compassionate, other staff did not treat people with consideration or respect. They lacked compassion and were not caring. This was confirmed by social care practitioners from the local authority who had observed staff working. One told us, "Some staff are lacking care; they have no interest in caring."

Staff did not support people to eat in a dignified way. For example, at breakfast on the second day of the inspection, we observed a staff member supporting two people to eat porridge at the same time. They gave neither person their full attention. They overloaded the spoons and, as a result, porridge was running down their chins and onto their clothing. One person had a clothes protector in place, but the other person did not, so the porridge ran onto their top. There was no interaction between the staff member and the people they were supporting, other than them being told to "come on, open your mouth". At lunchtime, on the second and third days of the inspection, other staff members also supported two people to eat their meal at the same time. This did not demonstrate respect for people's dignity. A further person who was struggling to use a fork asked for a spoon. One staff member declined to get a spoon and told the person, "You do alright with a fork", although a second staff member did fetch a spoon, which the person then used.

We observed a lady sitting with other people in the lounge. They were living with dementia and needed staff to select their clothes and support them to dress. They had not been dressed in a bra or undergarments and when they repeatedly lifted their jumper up to suck the edge, they exposed their breasts. We saw another person laid on their bed wearing only a continence pad that was not fitted correctly and compromised their dignity.

Another person entered the lounge with their catheter bag hanging out from the bottom of their trousers. This compromised their dignity and their safety as it was at risk of being pulled out of position. This went unnoticed by staff for nearly an hour, at which point the bag was then strapped to the person's leg in full view of other people in the lounge.

In the middle of the morning, a person was sleeping in a chair in the 'quiet lounge' when they were woken by a staff member who offered to take them upstairs for a shave. The person, who was living with dementia, looked confused, shut their eyes and the staff member left them. It had been unnecessary to wake the person. The timing of the offer of a shave appeared to have been at the convenience of staff rather than to suit the wishes of the person.

We saw a person in the dining room waiting to use the bathroom. A staff member waiting with the person

explained to a second staff member that the person was waiting. The second staff member responded irritably, in the presence and hearing of the person, and said, "Alright! She knows the drill. She'll have to wait."

We observed a staff member approach a person who was sitting with their legs crossed. They said, "Shall we uncross those legs of yours?" Without giving the person time to respond, they abruptly pulled the person's legs apart to uncross them. The person appeared disorientated and shocked and said, "No", but it was too late, the staff member had already acted.

On two days of the inspection, we observed people's washing draped over a rotary washing line in the garden. Staff had not used pegs to secure it, so some had fallen onto the grass below. Two family members and a social care practitioner told us laundry arrangements were disorganised; people's clothing often went missing and people were sometimes given other people's clothes to wear. Another family member said, "Once or twice [my relative] has had other people's clothes on." We saw people's clothing was not hung or folded in their wardrobes. Piles of clothing were seen screwed up in the bottom of the wardrobes and other clothing was jumbled up with sheets and pillows on shelves. One person's wardrobe was being used to store three hoist slings and a screwed up continence sheet. Most people were unable to access their wardrobes without support and relied on staff to look after their clothes for them. The way staff treated people's clothes demonstrated a lack of respect for them and their property.

When we visited a person who was resting on their bed, we saw three wheelchairs and a hoist were being stored in their room. The person was living with dementia, but did not need to use this equipment. Rather than create a pleasant space for the person to spend time, staff had chosen to use the person's private bedroom as a store room. This demonstrated a lack of consideration and respect.

Confidential information was not always kept secure. People's care plans and risk assessments were kept in an office adjacent to the main communal areas of the home. The door had a lock, but we noted that this was not always used and the office was often insecure, giving open access to this confidential information. Food and fluid charts were used by staff to monitor the amount people ate and drank. We saw these were kept on the dining tables, in full view of people and visitors. On two occasions, we observed people reading information relating to other people.

The failure to ensure people were treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, other staff were more compassionate. For example, when a person complained of feeling cold, they were offered a blanket. We overheard a staff member interacting positively with a person while supporting them with personal care (behind a closed door). They explained what they were going to do, praised the person for their efforts and calmly reassured them. They finished by saying, "Alright [person's name], we will just get your bottom dressed, and then shall we get your breakfast?" A family member said they had heard staff asking permission before entering people's rooms. The registered manager told us they explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans.

People's care plans had been developed with input from the person and their family members, where appropriate. However, people were not always consulted. For example, on the second day of the inspection, we saw new quilt covers had been purchased. These were all the same and no consideration had been made in relation to individual preference. Similarly, people were not consulted about a decision by the provider to change the activity programme. A staff member told us, "[People] didn't get asked [about the

decision] and nor did we."

Care plans encouraged staff to promote people's independence by indicating the tasks people were still able to perform for themselves. For example, one person's care plan stated: "I am able to wash my hands and face and most of my upper body. I require assistance with washing my back and lower body." Staff had been supporting one person to do physiotherapy exercises following an injury. We heard them giving encouragement, direction and support when the person mobilised with their walking frame to promote independence. However, other people's care plans were not always followed in a way that promoted their independence.

Inadequate

Is the service responsive?

Our findings

Staff were not responsive to people's needs and people did not always receive the care they needed. One person told us, "I sometimes don't get my bath. [Staff] say 'sorry, not today'." A family member told us their loved was "totally dishevelled" when they picked them up after a week's respite stay at the home. They described how their relative's toiletries, flannel and towel had not been used and the person was in urgent need of a shower. Another family member said, "[My relative] doesn't get shaved. I do it once a week. I do it on a Monday, but [I know] it won't get done again until next Monday as staff don't have the time."

We saw other people appeared dishevelled; their clothes were creased and dirty and one person had dirt under their finger nails. Another person's records showed they had not received personal care for the previous seven days, but no explanation had been provided. A further person's care plan stated: 'I need encouragement to brush my teeth, I require the carer to push me up to the sink to undertake this.' However, we saw the person's sink was completely dry and had not been used. Their toothbrush and other people's toothbrushes were dry and had hard, dried-up toothpaste on them. It was evident people had not been supported to use these. Most people required help to wash; however, we saw there was no soap in four people's en-suite bathrooms and the soap in other people's rooms was dry and cracked, indicating it had not been used recently.

Staff showed us a bath rota showing that most people had requested one bath a week. They explained that this was just a guide and said people could have baths whenever they wished. However, the records for the week before the inspection showed only eight of the 22 people being accommodated had received a bath.

Staff were unable to recognise when people needed support. For example, we observed a person sitting on a hard chair, slumped at a dining table asleep. A staff member told us the person had been there for about an hour, but they had not thought to offer the person support to move to a comfortable chair until we suggested it. Another person had been left in a basic wheelchair at the table for over two hours. The wheelchair was not designed for extended use; this would have been uncomfortable for the person and put them at greater risk of developing pressure ulcers.

We observed a further person being blinded by bright sunlight. They appeared distressed and were moving their hand and their head to try and avoid the sun, but were unable to communicate their needs due to a cognitive impairment. We pointed this out to a staff member who tried drawing the blinds and the curtains, but found they were broken and would not close. At our suggestion, they moved the person out of the sun, but did not talk to the person to explain what they were doing.

Another person did not receive appropriate support to manage their catheter. A catheter is a device used to drain urine from a person's bladder into an external bag. They are prone to blocking; therefore, it is important to encourage good fluid intake and to monitor the fluid output. The person needed support to empty their catheter bag, but when we met them on the first day of the inspection, we saw their catheter bag was so full it had expanded to a round shape and was bulging as staff had neglected to empty it. On the evening of the third day of the inspection, we saw the person was not drinking and their records showed

they had not drunk at all that day. Staff had not identified this as a concern, until we pointed it out, and they then sought medical advice. Following the inspection, we were informed that the person had subsequently been admitted to hospital with dehydration.

Care plans had been developed to provide information and guidance to staff about each person's needs and how they wished them to be met. However, these had not been reviewed since September 2017 and did not always reflect people's current needs. For example, although one person had been prescribed a thickener to add to their drinks, there was no information in their care plan to advise staff of the consistency required. Another person had fallen out of bed, resulting in a serious injury. When they had returned to the home, following treatment in hospital, they had been given a bed with bed rails to prevent them falling out of bed again; however, the person's care plan had not been updated to reflect this need, so we could not be assured that staff would use these consistently. Staff told us they did not have time to read the care plans and had to rely on word of mouth information from colleagues or by asking the person themselves.

On the second day of the inspection, a person arrived for a week's respite care. No staff member knew they were due. The person did not have care plan prepared and staff had no information about the person's needs or how to meet them. A staff member told us, "We didn't even know [the person] was coming in. It's the first time [the person] has been here and we've got no time to spend with them. We don't know what he likes, if he's allergic to anything etc." Daily records of the care provided by staff were not always completed. Where they were completed, they did not confirm that people's needs were met in a personalised way, as they were limited to comments such as 'personal care needs met by two staff'.

People were not supported to lead active lives through the provision of meaningful activities. One person told us, "We don't get many activities. We never get out and never go in the garden. I would really like to go out." The registered manager told us that most of the activities provided for people by an external company had been cancelled by the current provider, with the exception of a singer who still attended most weeks. In their place, staff were required to undertake activities with people in the afternoons. Although this had not been possible, they had organised several one-off events, including a Ritz tea party, a visit by a local donkey sanctuary and a Halloween party. A staff member told us "The new owner has cut [the activity provision]. It's the worst thing he could have done. [People] used to love it, doing all the arts and crafts and painting. We struggle to do anything with them instead, because of all the care work." Another staff member said, "I don't think there's enough [activities] for people to do. [Staff] don't have time to engage [with people]." On the second day of the inspection, the advertised activity was 'nail care', but staff only had time to do this with one person. On the third day of the inspection, no activities were conducted.

People had mixed views about whether they were empowered to make day to day choices. One person told us, "I usually just wake up when I want to", although another person said, "Just lately, I have been late [being supported] to bed; it was one o'clock in the morning recently. I prefer to go at nine [o'clock], but I can't get that." We heard some staff offering people choices, for example, asking people where they would like to sit, what they would like to eat and where they would like to take their meals`. At lunchtime, people were given the option of wearing a clothes protector and when one person declined, their wish was respected.

The failure to ensure people received appropriate care that met their individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had not received any complaints about the service since the current provider was registered, although feedback from the local authority indicated that family members had raised concerns with other staff but no action had been taken. We identified that the provider did not have a complaints procedure in place. Staff were using the complaints policy of the previous provider and this was

advertised on the home's notice board. The provider updated their complaints policy during the course of the inspection, but this was not circulated to people or their families.

Some staff had received training in end of life care and knew how to access specialist support when needed. One person's care plan confirmed that the person's end of life wishes had been discussed with them and their family. Written feedback from the relative of a person who had recently received end of life care at the home stated: "The care you gave was second to none, in particular in [my relative's] last weeks prior to her passing. For this I will be eternally grateful."

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The provider took over the operation of the service from the previous provider on 30 June 2017. Since taking over the service, the provider had failed to establish and implement clear working practices, policies, procedures or quality assurance systems. They had continued to rely on existing processes carried over from the previous provider. Where they had taken action, for example by cancelling pre-arranged staff training, they had failed to put alternative arrangements in place. Staff were only enrolled onto the e-learning courses after we had raised concerns about a lack of staff training during the inspection.

The provider did not act promptly to improve the service where deficiencies were identified. For example, they had failed to take any action in response to 58 "high priority" hazards identified by a fire safety risk assessment completed by a fire safety consultant two months previously, until we raised concerns during the inspection. Due to the concerns identified by the CCG medicines management team and by visiting social care practitioners, the provider was advised by a senior social worker to consider using an agency nurse to administer medicines to people; however, they failed to do this. When we spoke with the nominated individual of the provider, they were unable to explain why this recommendation had not been progressed. The local authority subsequently arranged for a community nurse to administer medicines over the following weekend and the nurse identified additional concerns with the way medicines were being managed in the home. This could have been avoided if the provider had acted more promptly.

There was no effective oversight of the service by the provider. Although a 'compliance manager' had been employed to support and monitor the other homes operated by the provider, these systems had not yet been established at Fairview House. Therefore, the concerns we identified had not been picked up or addressed.

There was not an effective quality assurance system in place. The registered manager acknowledged that they were "falling behind" with their checks and audits due to a shortage of staff. For example they told us that they monitored the incidence of falls across the home by completing a monthly audit. These had been completed for July and August, but not for September or October. We could not be confident that audits they had conducted were accurate. For example, their infection control audits for July, August and September 2017 showed "100%" compliance and no deficiencies. This was at odds with our findings, the findings of the local authority and the findings of the provider's compliance manager who conducted an infection control audit during the course of the inspection. During the inspection, a new system was established to check the people's beds and bedding twice a day; however, immediately after one of these checks we found the bedding on two people's beds was not appropriate or fit for purpose. The auditing process was, therefore, not robust.

Senior staff were required to conducted daily checks of all medicines subject to additional control by law and to check that previous staff had completed the medication administration records correctly. However, we found significant errors with the administration of people's medicines that had not been picked up by these checks.

Record keeping practices at the home were not adequate. The registered manager's office was disorganised; key information about people was still in their office and had not been communicated to staff. They struggled to find key information we requested during the inspection, including the home's fire safety risk assessment and gas safety certificate. They agreed to send us these documents after the inspection, but failed to do so. The provider's nominated individual told us later that the home did not have a current gas safety certificate due to an oversight.

The 'night book' used to share information between the night staff and the day staff went missing during the inspection. Social care practitioners reported that documents they had previous seen in people's care plans had then gone missing. 'Night cleaning records' had only been completed for one day in November 2017. Information recorded in people's food and fluid charts was not reliable. For example, one person's fluid intake chart did not correlate with their fluid output chart; if they had received all the fluid recorded, then their output would have been much higher. During the course of the inspection, one of the managers introduced a new form for senior staff to record when they had checked people's daily care records to help ensure their care needs had been met. However, we saw these were not always completed and people had not received all the personal care they needed.

The provider's nominated individual told us the culture of the service was "not good" and they felt they needed to reduce the number of people living at the home, so they could "start again". They were unable to provide an explanation as to why significant issues had not been picked up and addressed. They said they had been on "a huge learning curve" and acknowledged that they "didn't have controls in place" to ensure the quality and safety of service delivery.

The failure to operate effective systems to assess, monitor and improve the service and a failure to maintain accurate records were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of resilience in the management team. Staff shortages had led to the registered manager having to cover some care shifts, including two night shifts during the previous three weeks. This meant they were not available to do their day job. The deputy manager had been absent from work for a period of six weeks prior to the start of the inspection and this had had a significant impact on the capacity of the management team to keep up to date with day to day demands. For example, people's care plans had not been updated since September 2017; DoLS renewal applications had not been made and information about DoLS authorisations had not been communicated to staff. Between the second and third days of the inspection, the registered manager resigned, with immediate effect, leaving the nominated individual, who had no experience of managing a home, to run the service.

Senior staff were brought in from the provider's other homes to support Fairview House. However, they told us they felt overwhelmed by the scale of the task as there was "no organisation for anything" and they were having to implement new systems. They were working excessive hours, were exhausted and were close to tears. They were being supported by social care practitioners from the local authority, who told us they were identifying "serious concerns" with the care provision on a daily basis and felt the service was "not safe".

Staff were disorganised. Although a 'delegation sheet' was used to deploy staff to specific roles each day, their workload meant they could not always complete all tasks. For example, the night shift were required to do the laundry, but were often not able to, which had a knock-on effect on the workload of the day staff. Staff who had been brought in from the provider's other homes did not know people or understand their needs. They were not given clear direction and when not directly supporting people were seen standing around watching people, rather than engaging with them or offering proactive support. Senior staff told us

some care staff reported sick at short notice, or simply did not turn up for shifts. They highlighted one staff member who arrived for work, but immediately left as a particular colleague was not working the same shift.

Staff said they felt supported by the registered manager, who they described as "approachable". One staff member told us, "She is an excellent manager; she's always there is you need to talk." Another staff member told us "The [senior care staff] are spot on. I always feel I can talk to them; and [the registered manager] has supported us a lot." However, they added that they felt "stressed and not appreciated" by the provider and said, "A lot of us are feeling the strain [of the workload]."
Other staff left the service during the course of the inspection, including care staff, a cook and a cleaner. One told us staff morale was poor and added, "I have had enough, I think I'm going to leave."

The registered manager followed the duty of candour requirements. We saw an example of how they had done this, by sending the person's relative information in writing about a fall. A family member told us, "[My relative] had one fall at the beginning and they told me about it when I came in to visit. There was no injury." The covering manager from another home operated by the provider acted in an open and transparent manner. They raised safeguarding concerns when they found night staff had left two people in an unsafe position and had neglected to provide adequate care to three other people. These allegations of neglect have been referred to the police for investigation.

After the first two days of the inspection we wrote to the provider detailing our concerns. On the third day of the inspection we found that action had not been taken and the care and support afforded to people had deteriorated. Due to the level of concerns we identified, we liaised with the local authority who commission services at the home. As a result of these discussions, and due to the fact that the safety of people could not be assured, people were moved to alternative more suitable accommodation.