Quality Homes (Midlands) Limited

Oaks Court House

Inspection report

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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
Oaks court house is a care home providing personal care to for up to 41 older people. People have access to their own bedroom along with communal spaces including lounges and gardens. At the time of our inspection there were 35 people at the home, some who are living with dementia.

People's experience of using this service and what we found
When incident's and accidents had occurred, action had not been taken to reduce the risk of reoccurrence, placing people at risk of significant harm as these incidents continued to occur. Risks to people were not managed in a safe way and action was not taken to ensure people's safety. Safeguarding incidents had not been appropriately reported or investigated placing people at risk of harm. People did not receive their medicines as prescribed and there was a lack of guidance in place for 'as required' medicines meaning people may not have these when needed. There were no evidence lessons were being learnt when things went wrong.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There were concerns with the environment, the kitchen was unhygienic and other areas of the home were in need of repair. There were concerns with the risk of cross infection as staff were not always wearing masks correctly.

People did not always have access to health professionals and when advice had been sought this had not always been followed. There were not enough suitably trained staff to support people. Staff had not always received up to date training or some had not received training at all.

People were not involved with their care or were not always able to make choices throughout their day. There was no evidence to show how they were involved with this. Care plans and risk assessments were not always in place and staff did not have information to support people in a safe way. People's preferences were not always considered. People were not treated in a dignified way.

The systems in place had failed to identify concerns or areas of improvement. The lack of oversight in the home placed people at risk of harm.

We saw some nice interactions between people and staff. There was a complaints procedure in place that was followed when needed.

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 (4 September 2021)
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the care people received. A decision was made for us to inspect and examine those risks.

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

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oaks court house on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment of people including medicines management, staffing levels and staff training, the home's environment, the lack of dignity provided to people, how people are safeguarded, how people are involved with their care and how the home is governed at this inspection.

We issued a Notice of Proposal to vary a condition on the providers registration and remove the location Oaks Court House.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 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 responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led
Details are in our well-led findings below.

Inadequate

Oaks Court House

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 Health and Social Care Act 2008.

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

Inspection team
The inspection was carried out by two inspectors and an expert by experience. The expert by experience was used to make telephone call to relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oaks court house is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection, including notifications the provider had sent to us. We also gathered feedback from the local authority and other health professionals who had attended the home.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made the judgements in his report. We used all of this information to plan our inspection.

During the inspection
We spoke with 4 people living in the home, 8 relatives and 1 friend. We looked at the care records for 17 people. We spoke with the nominated individual, registered manager and deputy manager. We spoke with 6 care staff and a member of the kitchen staff. We checked that the care people received matched the information in their records. We also observed the care people received in communal areas. We looked at records relating to the management of the service, including audits carried out within the home.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure the environment was safe and we found this was poorly maintained. There were also concerns with infection control practices.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management; Lessons learnt when things go wrong

- People were not protected from risks associated with their care and support. Care plans and risk assessments were not always in place for people when needed or reflective of incidents that had occurred. We saw a person had 4 unwitnessed falls since moving into the home, 1 had resulted in hospital treatment. There was no falls risk assessment or care plans in place for staff to follow to keep this person safe. No action had been taken after the falls occurred to mitigate the risk of further falls. This placed this person at risk of significant harm.
- When people had displayed periods of emotional distress, we saw these incidents were documented. However, there was no clear guidance, care plans or risk assessments to show how to support people during these times. These incidents continued to occur, and this had resulted in assaults on people living in the home. This placed people at risk of significant harm.
- Opportunities to learn from adverse incidents had been missed. One person had left the home unsupervised on several occasions. Despite this, there was no care plan or risk assessment in place. Furthermore, failures to make improvements to the security of the environment meant the person could still get out, this placed them at risk of harm.
- Failure to maintain the environment placed people at risk of harm. The broken toilet seat exposed hot pipes and waste that was stored in the wheelchair placed people living with dementia at risk if they entered these areas. We saw people living with dementia walking around the home independently. We have reported upon this further in the 'effective' section of this report.
- After our inspection visit on the 23 November 2022, we told the provided to take immediate action to keep people safe. We continued our inspection on 28 November 2022 to see if the provider had taken the action, they told us they had. The provider sent us copies of risk assessments and plans that had been introduced for people. We found these lacked detail and guidance for staff to follow. Furthermore, when we inspected on 28 November 2022, staff were not always aware of these plans and they were not always being followed. This continued to place people at risk of significant harm.

Using medicines safely

● People did not receive their medicines as prescribed. When people were prescribed 'as required' medicines they were receiving this on a regular basis. This included medicines for agitation, pain relief and bowel management. There were no records in place stating why they had received these medicines and if they had needed them.

● When people were prescribed 'as required' medicines there was no guidance in place for staff to follow to show when people should receive these medicines. This meant people were at risk of not receiving their medicines when needed.

● After our inspection visit on the 23 November 2022, we told the provided to take immediate action to keep people safe. We continued our inspection on 28 November 2022 to see if the provider had taken the action, they told us they had. The provider sent us copies of 'as required' guidance that had been introduced. These lacked detail and direction for staff to follow. The provider also told us they would review all 'as required' medicines with the GP. On 28 November although they had contacted the GP reviews had not taken place. People continued to receive these medicines regularly with no records in place to say why. This meant people continued to receive medicines they may not need.

Preventing and controlling infection

● We were not assured the provider was using Personal Protective Equipment (PPE) effectively and safely. Not all staff were wearing masks in line with guidance. There were no risks assessments in place for this. We observed on numerous occasions staff were not wearing their masks correctly, including around their chins and not covering their noses. This meant people, staff and visitors were exposed to the risk of cross infection.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● When people we prescribed regular medicines, we saw these were administered to people when needed. We saw staff spent time with these people ensuring they had taken the medicines before leaving them. We also saw medicines were stored safely.

Systems and processes to safeguard people from the risk of abuse

● People were not sufficiently protected from abuse. Although there were procedures in place to manage safeguarding concerns, when incidents of potential abuse had occurred, they had not always been appropriately documented, investigated or reported so they could consider any further actions. For example, we saw documented incidents where a person had hit another person. There was no evidence this had been investigated or escalated. This placed people at continued risk of abuse.

● During our inspection we highlighted a series of concerns with the registered manager and the nominated individual. This included, a person receiving a diet that placed them at risk of choking, a person leaving the building, when it was unsafe to do so and people not receiving their medicines as prescribed. No action was taken to investigate or escalate these incidents by the home. We raised these with the safeguarding team after our inspection.

● The training matrix we reviewed showed not all staff had up to date or had received safeguarding training. Not all staff we spoke with were aware of safeguarding or the procures to follow.

People were not always protected from potential abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and recruitment

● There were insufficient staff to provide people with the support they needed or to ensure they were safe. T We received mixed reviews on staffing levels in the home. One person told us, "I don't really wait but the staff are always rushing, one more would benefit us all." A relative told us, "There are always enough staff when we are here." Staff we spoke with felt there were not always enough staff. One staff member said, "There's not enough for the types of people that live here. We have asked for more. It's hard work."

● The registered manager told us the communal lounge should always have a member of staff located there to manage risks to people's safety. During our inspection we observed multiple times when the lounge was unsupervised, as staff were supporting other people. People with known risks, were present. During these times we saw people who needed support with mobility, were mobilising independently and a person who could not leave the building due to risks, left on two occasions. This meant there were not enough staff to follow the procedures in place to keep people safe.

● The provider used a dependency tool to calculate the number of staff required based on people's individual needs. Although there was the correct amount of staff available based on this tool, we could not be assured by the accuracy of this. For example, as people did not always have care plans in place that reflected their needs, we could not be assured the information inputted into this tool was correct.

There was not enough staff to meet people's needs and keep them safe. This placed people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw staff had received the relevant pre employment checks before they could start working in the home, to ensure they were safe to work with people.

Preventing and controlling infection

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● There were no restrictions placed on visiting and visitors could access the home freely.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has changed 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

- There remained a series of concerns with the environment including the kitchen. There remained unclean areas such as the walls, the floor, the cooker hob and equipment such as pots and pans. We also identified food items were left on dirty surfaces uncovered, food was out of date and not stored as required. This meant people were placed at risk of harm as appropriate standards of hygiene within the kitchen environment had not been maintained.
- We found concerns within other areas of the home. This included, a toilet seat was broken and not fixed to the toilet and hot water pipes exposed with a bathroom, increasing the risk of people burning or scalding themselves. The registered manager told us this bathroom was out of use and waiting for a refurbishment. We found this was unlocked and could be accessed by people living with dementia.
- We also found rubbish was stored outside and a yellow bag of waste was stored on a wheelchair in a bathroom. This placed people at risk of harm should they access this.
- After our inspection visit on the 23 November 2022, we told the provided to take immediate action to keep people safe. We continued our inspection on 28 November to see if the provider had taken the action, they told us they had.
- Although some improvement had been noted in the kitchen area, there remained concerns as food was still left out uncovered and areas of the kitchen remained unclean.

Premises and equipment were unhygienic and poorly maintained. This placed people at risk of harm. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always have the skills or knowledge to support people. For example, we reviewed the training matrix this showed that some staff had not received training in areas such as IPC, safeguarding, dementia and challenging behaviours. Other staff training was not updated in line with the training matrix.
- Staff had not received training to support people. This included supporting people to eat and drink in a safe way and we found concerns with the diets people received. Staff could not demonstrate how to support people with periods of emotional distress. This placed people at risk of harm.

Staff did not have update training or an understanding how to support people. This placed people at risk of harm. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

We checked whether the service was working within the principles of the MCA.

● The principles of MCA were not followed. When capacity assessment had been completed, they were not individual or specific to the decision being made. For example, one person's MCA related to overall capacity. There was no evidence to show how the decision had been made.

● We did not see any best interest decisions in place for people.

● It was unclear who had a DoLS in place, we saw a form that had been completed by the registered manager that showed dates of when DoLS had been authorised. There were no copies of DoLS available for us to review. The registered manager or staff were unable to tell us how people were being restricted. This placed people at risk of being unnecessarily restricted.

● Two people were receiving their medicines covertly. Covert medicines are medicines that are administered in a disguised format and the person does not know they are taking them. There were no MCA, best interest decisions or care plan in place for these. This meant decisions were being made on people's behalf without legal authority.

●There was a lack of understanding from the registered manager and staff around what capacity was. Staff had not always received up to date training in this area.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People did not always have access to health professionals, when needed. For example, it was documented one person mobilised with a walker. We observed the walker was not being used during our inspection. Staff told us they had removed this walker from the person as it was not safe for them to use. This person had not been referred to a health professional for advice or a review.

● Between our inspection visits the local authority had arranged for an occupational therapist (OT) assessment for this person. When we visited the home on 28 November 2022, this had been completed. There were no updated plans in place stating the advice given by the OT.

● Furthermore, we saw this person was mobilising independently and not being supervised in the communal lounge. This was not in line with the advice from the OT and placed this person at significant risk of harm.

● People's health was not managed in a safe way. As reported on under safe, people received 'as required' medicines regularly. For one person was saw they received medicines to help them go to the toilet. Despite documentation to show this person had bowel movements they continued to receive these medicines

without any clear rationale.

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

● People were not provided with the diets needed to keep them safe. We identified a person had received a verbal instruction to receive a soft diet, following a hospital admission. There was no care plan or risk assessment in place for this and staff were unable to tell us what constituted a soft diet. During our inspection we saw this person was offered a diet that was not soft. This placed them at risk of choking.

● After our inspection visit on the 23 November 2022, we told the provided to take immediate action to keep this person safe. We continued our inspection on 28 November 2022. On arrival we saw this person was eating toast, this is not a soft diet. We discussed this with the staff member who told us they were not aware of the person diet. This placed this person at significant risk of harm.

People health needs were not consistently managed, and professional advice was not always sought or followed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed views on the quality of the food in the home. Some people told us they enjoyed the food and were offered a choice. One person told us the meal they had been served "Was not very nice", they told us they had eaten it rather than to be hungry. They also told us they had not been offered a choice. During lunchtime we saw several meals were sent back to the kitchen by people.

● Although the registered manager told us there were a choice of meals available, we did not see that anyone was asked what they would like.

● It was also unclear how people living with dementia were offered choices, there were no pictures or prompts used to help people make these choices.

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

● People's care plans did not always reflect their current needs. Some people did not have care plans, risk assessment or guidance in place at all.

● Some people's needs were assessed prior to the start of their care. However, these were not always updated to reflect changes in their needs or professional advice given.

● People's involvement in the planning and review of their care was not reflected within their care documents.

● We did not see plans in place showing how people were supported with their oral health care.

The provider failed to ensure that people received a service that was person centred and reflected their personal preferences and individual needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

At our last inspection we identified people were not always respected. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

Respecting and promoting people's privacy, dignity and independence

- People were not supported in a dignified way. For example, we saw a person was eating breakfast in the lounge unsupervised. They were drinking a hot drink with a spoon; they spooned the hot drink on to their toast before eating it. There were no staff available to offer support to this person. This meant this person was not supported to eat their meal in a dignified way.
- We saw another person was sat in a pool of urine for 11 minutes before they were offered support. Daily records showed this person was last assisted over 8 hours before the incident occurred.
- Peoples mealtime experiences were not dignified. We observed 2 people asked for a drink, they were told by staff they had to wait until some cups had been washed and dried before they could have one, as there were no others available.
- All people's meals were served in plastic plates and dishes, with no assessed need for this. There were no condiments available for people. Throughout mealtimes there was intermittent support available for people, we saw they fell asleep during their meals and dropped food as they were not provided with support.

People were not supported in a dignified way. This placed people at risk of harm. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw that some people's privacy was respected for example, when people were involved in personal care. When they were in their bedrooms supported by staff the doors were shut.

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

- People were not always given choice and care was provided to them rather than them being involved in their own decisions. For example, we observed people being given meals without always being asked what they wanted.
- There was no evidence to show how people were involved with their care or reviews. Most people were unable to tell us about their experiences.

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

● We did see some kind and caring interactions between people and staff. One person told us, "The staff are lovely to me they are very kind." A relative commented, "They [staff] are never short of a smile. They stop and chat by my relations room, jokes and we have a laugh."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- For some people there were no individual care plans or risk assessments in place. There was no guidance in place to ensure staff were able to support people as needed and in a safe way. The oversight placed people at risk of significant harm.
- When people had individual needs and plans were in place, they lacked detail. People's preferences were not always included in their care plans. For example, one-person care plan had a section that related to 'dressed/undressed preferences. The only information recorded in this section was' will require assistance from two staff to maintain her safety'. There was no reference to what this person's preferences were. The' grooming preference' section for this person's care plan was blank.
- People's care needs were not regularly reviewed and where they were, there was no evidence people, or their relatives were involved in the review process.
- End of life care plans were in place for some people. However, these were not always fully completed and did not consistently state people's preferences. Most plans we reviewed contained the same information. For example, they wished to remain at Oaks Court House and their second choice would be hospital.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People did not consistently have their communication needs assessed. When people did have care plans in place, they lacked detail. For example, one person's communication plan stated, staff are to 'promote good communication through speaking, listening and body langue'. There was no other information documented. For other people this section of the care plan was blank.
- People were not supported to communicate in a way that met their dementia related needs. This meant that decisions were made for them due to people's communication needs not being fully considered.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to access a variety of activities in line with their preferences. We did not see any activities taking place doing our inspection. We were told there was an activities co-ordinator who

completed activities with people on other days. We saw in the dining area that the same film was played twice during our inspection.
● People had limited, task-based communication with staff. We saw people living with dementia had limited engagement and choice around how to spend their day. This resulted in many people spending long periods of time sitting in lounge areas with no engagement and asleep.

The provider failed to ensure that people received a service that was person centred and reflected their personal preferences and individual needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were able to maintain relationships with people who were important to them. People were able to spend time with friends and family as they wished to do so.

Improving care quality in response to complaints or concerns
● People and relatives told us they knew and felt able to complain.
● There was a complaints policy in place. When complaints had been made the provider had responded to these in line with their policy.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to operate good governance systems to assess, monitor and improve the quality and safety of the services provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

The service has a history on non-compliance which dates back to 2019. This is the fifth time we have inspected this service and the highest rating achieved is requires improvement.

Continuous learning and improving care.

- There were no audits completed on the incidents and accidents at the service. There was no clear process or consistent oversight of accidents and incidents that had occurred at the home. When accident/incident report forms had been completed there was no oversight to ensure action was taken if needed to reduce the risk of reoccurrence. This lack of oversight placed people at continued risk of harm.
- The registered manager told us they analysed incidents and accidents by completing a safety cross, this identified incidents that had occurred in the home such as falls. This was not effective as it had not captured all incidents that had occurred. The registered manager was unable to demonstrate how you used this information (within the safety cross) to drive improvements within the service.
- The system in place to audit medicines was ineffective. It had failed to identify that people were not receiving their medicines as prescribed. It had not identified there was no information in place for people to receive their medicines covertly. It had also failed to identify there was no guidance in place for the administration of 'as required medicines for people. You had failed to ensure effective systems were in place to monitor the quality and safety of care in relation to medicine administration.
- There was no system or oversight in place in the home to monitor staff training. We found some staff had not had training in areas, such as dementia, DoLS and IPC and other staff training was out of date. You had failed to ensure staff were adequately trained to deliver safe care to people.
- The system to ensure sufficient staffing levels were in place was not effective. A dependency tool was in place and this was followed. However, we found people had to wait for support, they were not treated in a dignified way and there were not enough staff to answer call bells, supervise the communal lounge as required or support service users at mealtimes. This dependency tool was therefore ineffective.
- The electronic system used to monitor care plans was not identifying where care plans and risk assessments had not been put in place, for example MCA assessments. You had failed to ensure effective

systems were in place to monitor the quality and safety of care.

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

● Infection control procedures were not followed. We raised concern as a staff member was not wearing a mask in line with guidance. The registered manager confirmed there was no reason as to why they should not be and felt this was the staff members responsibility. They had not considered the risk of cross infection. They confirmed there was no risk assessment in place for this. The lack of oversight and failure to follow guidance placed people staff and visitors at risk of cross infection.

● Systems to ensure that the kitchen was cleaned, and food items stored hygienically were ineffective. We raised concerns about the kitchen environment with the registered manager who said it was the cook's responsibility and they did not carry out any additional checks. We discussed this with the provider, and they confirmed there was an expectation the cook would keep the kitchen clean and the registered manager would monitor. There was no system in place that monitored the kitchen.

● The system to ensure the policy of having a staff member based in the communal lounge at all times was ineffective. We were told throughout our inspection the communal lounge should always have a staff member in to keep people safe. We observed multiple times when the lounge was unsupervised, and people were present. There were no systems in place to ensure staff were present and there was no monitoring of this from the provider or the registered manager. The registered manager told us it was the responsibility of staff to allocate themselves. The lack of oversight placed people at risk of significant harm.

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

● There was no evidence to show how people were involved with their care.

● Although we saw some feedback was sought from people, such as food survey these had not considered all areas of the home and there was no evidence to show how this information was used to drive improvements.

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

● Poor communication and oversight were a theme throughout our inspection which did not promote good outcomes for people. For example, accidents and incidents were not reviewed or information used so lessons could be learnt.

Working in partnership with others

● There was no system in place to ensure referrals were made to healthcare professionals when needed if potential risk was identified. This meant people did not always receive a professional assessment when needed to mitigate risk to them and ensure they received the appropriate care and treatment.

There remained insufficient oversight on the service and the measures in place were not always effective in identifying areas of improvement. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Whilst the legal responsibilities in relation to the duty of candour was understood, the service had failed to ensure they were aware of all accidents, incidents and near misses at the service so they could ensure they were consistently meeting this. There was a failure to act upon all potential safeguarding concerns that had

occurred in the home.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people received a service that was person centred and reflected their personal preferences and individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential abuse.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not supported in a dignified way.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not working within the principles of MCA.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were unhygienic and poorly maintained.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Accommodation for

persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There remained insufficient oversight on the service and the measures in place were not always effective in identifying areas of improvement.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not enough staff to meet people's needs and keep them safe. Staff did not have update training or an understanding how to support people.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care