The Fremantle Trust

Icknield Court

Inspection report

Berryfield Road
Princes Risborough
Buckinghamshire
HP27 0HE

Tel: 01844275563
Website: www.fremantletrust.org

Date of inspection visit:
17 September 2019
18 September 2019
19 September 2019

Date of publication:
20 January 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Icknield Court is a residential care home providing personal and nursing care up to 90 people. The service accommodates people across two floors, each of which have separate adapted facilities. There were six 'houses' or 'units', three of which specialised in providing care to people living with dementia. At the time of our inspection 81 people were using the service.

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

Medicines were not managed safely and placed people at risk of not receiving the correct medicine at the right time. Some people had not received their medicines due to insufficient stock. People did not receive the support they required in a timely manner. Call bells were not always within people's reach to ensure they could call for help if they needed it. Risk assessments and care plans did not provide staff with all the information they required to keep people safe. Accidents and incidents had not been analysed so that lessons could be learnt, and preventative action taken.

Best practice guidance was not followed to ensure people received good quality care and support. Staff training was not up to date and therefore we could not be sure that staff had the skills and knowledge they required to carry out their role. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

Information about people's preferences was minimal. Care plans did not contain vital information to keep people safe.
The governance systems were poor and although some issues had been identified by the provider there were serious shortfalls at the time of our inspection that meant we could not be assured that people would receive safe and appropriate care.
Complaints had been recorded and responded to. End of life care was provided. However, staff had not received training in this area.

Recruitment procedures had been followed to ensure staff were suitable to work with vulnerable people. People had sufficient food and drink. A variety of activities were provided to ensure people were not socially isolated. People were supported to attend healthcare appointments.

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

Rating at last inspection
The last rating for this service was requires improvement (published 2 August 2018). There were two breaches of regulations. The provider completed an action plan after the last inspection to show what they

would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to unsafe management of medicines, safe care and treatment, providing personalised care, staffing and governance. We have served warning notices in relation to safe care and treatment and good governance.

Follow up

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

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?

Inadequate

The service was not safe

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Icknield Court

Detailed findings

Background to this inspection

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

Inspection team
Three inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type

Icknield Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. When a registered manager is in place they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first day and was carried out over three days.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was asked to complete a provider information return. We used the information the provider sent us in the provider information return as part of our inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This

information helps support our inspections.

During the inspection-
We spoke with five people who used the service and five relatives about their experience of care. We spoke with the Chief Executive Officer, the Regional Director, the Managing Director, the interim manager, the Head of Care and Clinical Governance, a visiting community nurse and five members of the care team.
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 reviewed a range of records including each person's medication administration record (MAR), eight people's care plans and records relating to their care plans. In addition, we reviewed recruitment records and other records relating to the way the service is run.

After the inspection

We continued to seek clarification and assurances from the provider that action had been taken to mitigate the immediate risks to people that we identified during our inspection.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management
• Risk assessment were not always in place for known risks. We saw people who were on a puréed diet, had catheters insitu and had pressure ulceration did not have risk assessments in place. This meant we could not be assured that these risks were being managed and staff didn't have access to information about how to mitigate these risks for individuals. This put people at risk of avoidable harm. For example, people on a puréed diet would be a t risk of choking, people with pressure sores may be at risk of increased skin damage if staff were not alerted to managing the skin to minimise further damage. For example, through repositioning the person and monitoring their skin. People with catheters insitu may be at risk of the catheter becoming blocked or suffering from urine infections due to poor practice in managing the catheter.

•Risk assessments that were in place were not always accurate. We saw one person's risk assessment for the use of oxygen stated the oxygen cylinder had to be checked every two hours. This was to ensure the cylinder was working correctly, adequate oxygen was in the cylinder and the setting was correct. The person had recently returned from hospital with respiratory problems and the oxygen had been prescribed by the hospital consultant. The oxygen was essential and was required continuously to ensure the person sustained adequate oxygen levels. However, charts we viewed were not always completed to show this had been done.
• In addition, we saw the recording of one chart had been falsified. For example, we saw the chart had not been completed on 17 September 2019 from 08.30 on the first day of our inspection. However, when we checked the chart the following day we saw it had been completed to say the oxygen cylinder had been checked. This could not be the case as we were visiting the person and their family in the person's room at the time the chart had been recorded as 'checked oxygen'. This demonstrated that risks were not appropriately managed. We brought this to the attention of the provider who said they will investigate this.

• People were at risk of not being able to summon help if they needed to. We saw that people's call bells were not always within reach. Some people told us they did not know they had one. We saw call bells under beds with some clipped to furnishings. One person told us, "I haven't got a call bell, I don't know really what I would do if I needed anybody." We saw the person's call bell under their bed.
• Another person told us, "I have falls regularly that is why I am here, but last time I fell, I could not reach my bell and had to wait until they found me."
• We received another comment relating to being able to summon help… "If I ring my bell they say, 'I'm busy' and go off and leave me. One or two carers get a bit annoyed if I ring my bell, one is sharp in her

manner, so I think twice about pressing it. Some can snap your head off, but others can be very good."
• One other person told us, they could only summon help if they pressed their bell on the wall when they were in bed.
• One relative told us, "I have visited mum many times and mum's call bell is nowhere near her. Mum phoned me once to say she needed help and couldn't reach her bell. I had to phone the office to go and sort mum out. The relative went on to tell us, "The carers seem stressed they whizz in and out."

Failure to assess the risks to people's health and safety placed them at risk from avoidable harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
Medicines were not safely managed
• We saw poor unsafe practice in relation to medicine administration. We observed a member of staff during the medicine round. The member of staff told us they had not worked on the unit before so were not familiar with everyone.
• The member of staff took people's tablets from the medicine trolley put them into individual containers and proceeded to locate where people were to enable the member of staff to administer the medicine.
• Some people were in the dining room and some were in their bedrooms. However, the member of staff did not take the medication administration record (MAR) with them to identify from the record if it was the correct person they were giving the medicine to.
• We asked the member of staff when they had their medicine training they told us it was two years ago. We brought this to the attention of the provider. Who said, "this will be investigated".
• One relative told us, "They gave [family member] the wrong dosage of drugs three times." The relative went on to say that things had improved since.
• In addition, we found a total of 10 people had not received their medicines due to lack of stock. The medicines ranged from medicines to alleviate symptoms of dementia, pain and to help people sleep. Not receiving these medicines may have an impact on people's health and well-being. The amount of time the medicines were not available ranged from two to five days.
• In addition, one person told us staff "give me my tablets but don't always see me take them only if they have time it depends on who it is (member of staff)."
• We saw some MAR charts were not correctly completed. For example, we saw several entries where staff had not given the person their medicine because it was 'too close to the morning dose'. However, we could not be sure what time the morning dose had been given as staff had signed for the morning medicine at the time specified on the medicine record rather than what time the medicine had been administered. This puts people at risk of not receiving their medicines including pain relief at regular intervals to ensure pain was managed effectively.

The provider had failed to ensure the safe management of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Staff told us that staffing levels were not always adequate to meet people's needs. One member of staff told us, "Sometimes I have been here with just an agency member of staff. You have to show them the ropes this puts us behind. I can't count the number of times I have wanted to throw the towel in." Another comment was, "We are so short-staffed, morale is very low." The member of staff was asked to come in in the evening to administer evening medicines. We noted on one unit there were two members of staff to support 14 people. We were told the third member of staff had to go to another unit to take someone to an appointment.

• We were told and rotas we saw confirmed three staff were allocated to each unit. However, staff and relatives told us this was not always the case. One relative told us, "We are overall happy even though there aren't always three staff around."
•We received information relating to staff leaving a person on the toilet whilst they (staff) went to another unit to attend to other people. The person was found by another member of staff naked on the bathroom floor. The person explained that staff had left them for hours on the toilet and they tried to get up and fell. We were informed the person's frame had not been left within reach. This was an indication that staff were rushed and ineffectively deployed to ensure people's needs were met.
• We observed and were told the service used "quite a lot of agency staff". The agency staff on duty did not know people well and were unable to offer them the right support . We heard one person who was in their room calling out for help on the first day of our inspection. We went into their room (there was no call bell visible) the person told us they were in pain and needed help. We told the person we would go and find a member of staff to help. We found the only member of staff visible on the unit and asked them to help the person. The member of staff was agency and they told us, "I can't help as I don't know [the person]." We were told by the agency member of staff [the person] will have to wait until a regular member of staff becomes available. This conversation was overheard by the interim manager. We discussed this with the manager. They said they would investigate why the agency staff was reluctant to attend to the person.

The provider did not deploy sufficient numbers of staff to make sure people's care needs were met. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

•Staff received safeguarding training when they first joined the service. Staff we spoke with told us they knew what abuse was and they would report any concerns following the correct procedure.
• Statutory notifications were sent to us to inform us of any events that placed people at risk.

Preventing and controlling infection

• The service was cleaned to high standards. We saw staff used personal protective equipment when attending to people's personal care. Staff received training in infection control.

Learning lessons when things go wrong

• We saw that data reports relating to accidents and incidents were available we did not see these had been used to identify trends and action taken to prevent reoccurrence.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

• Care assessments were carried out prior to people moving into the home. However, information was not always available for all areas of need where people required support. We saw one person who had been admitted to the service in August 2019 did not have any information in their care plan about how staff should support them. We saw the person had a catheter in situ and a skin lesion on their face. In addition, there was no information relating to the person's ability to mobilise.

• We asked staff how they supported the person with their catheter and one member of staff told us, "I didn't know [person] had one. Another member of staff told us they did not know how to empty the person's catheter. We saw the person had not received any oral care since they had been admitted to the service and staff recorded 'no oral care given-no toothbrush'.

• We visited the person in the afternoon in their room and they looked dishevelled and were still wearing their pyjamas. Staff told us the person did not want any personal care. We saw records of personal care and saw the person had not had a bath or shower in the time they had lived at the service. There was no evidence to show that this person's needs had been fully assessed and explored to ensure their needs were met. We reported our concerns to the local authority for further investigation. We also told the manager about our concerns who said this would be addressed with immediate effect.

• We saw conflicting information relating to people's food intake and dietary requirements. Examples were, one person having a steady weight loss since admission with a malnutrition score showing a medium risk but a high-risk nutritional care plan in place. We saw the GP was contacted to request calorie shots for the person and the service told the GP weekly weight monitoring was taking place, but we only saw evidence of monthly weights recorded. There was no outcome recorded regarding the contact with the GP.

• Another person had been seen by the Speech and Language Therapist (SALT) and was advised to have thickened drinks if they became chesty or were coughing. This information was not transferred to the person's care plan. In addition, the person was advised to have their food intake documented, to have fortified meals and to be weighed weekly. We did not see any evidence that these actions were taking place.

People's needs were not always recorded or effectively met. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• We saw people had access to sufficient food and drink throughout the day. People told us the food was

good and there was plenty of it… "Yes, we get a choice", "The food is alright I suppose."
• People received assistance with their meals when required. We saw the kitchen had a list of people who required additional calories to promote weight gain.

Staff support: induction, training, skills and experience
• We received negative comments from staff we spoke with about the level of support they received. Comments were, "There is no leadership", "We are at rock bottom", "There are constant changes we don't know where we are from one day to another", "Supervisions are here and there."
• We asked to see the supervision matrix. However, this could not be found. We concluded that staff had not received supervisions on a regular basis to ensure they were competent in their role as the provider was unable to confirm or provide evidence of this.
• New staff completed the Care Certificate, which identifies a set of standards that health and social care workers should adhere to. We viewed the training matrix which showed several members of staffs' training had expired. The matrix showed an overall compliance of 58.45 percent. This demonstrated staff were not adequately trained and therefore we could not be assured that they had the skills and were competent to meet people's needs effectively.
• We saw some staff who were monitoring oxygen and attending to people's catheters had not received training in this area to ensure that they carried out this tasks appropriately and safely.

Failure to ensure staff had the necessary training and support placed people at risk of being supported by staff who may not be competent to carry out their role effectively. This was a breach of regulation 18 (staffing) 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
• Relatives did not always feel that staff noticed their family member may have a health need.
• One relative told us, "We always point out if mum needs the doctor as she doesn't tell them when she is in pain and we always notice. Recently we noticed mum had very swollen legs, so we told the office and the doctor came out and gave her some tablets." The relative went on to say, they noticed their family member had very sore skin under their abdomen, so they had to ask the office to make sure their relative had a bath and skin care. Another relative told us they had to prompt the staff to get the doctor to see their family member. While another relative confirmed they phoned the doctor themselves to discuss their family members medical situation. This demonstrated the service had not observed or identified people's deteriorating health and had not taken action when required.
• Staff supported people when they had to attend appointments such as dentists, chiropodists and opticians.
Ensuring consent to care and treatment in line with law and guidance

At our last inspection care and treatment of people using the service was not provided with the consent of the relevant person. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was now meeting this regulation.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Staff told us they gained people's consent to receive support. We saw staff asking people where they wanted to sit and where they wanted their lunch.
• Where restrictions had been placed on people's liberty to keep them safe, authorisations had been applied for to ensure that this was lawful and people's rights protected.

Adapting service, design, decoration to meet people's needs
• The service was bright and airy with lots of crafts displayed throughout the premises.
• The service was purpose built and fully equipped to meet people's physical needs. The premises were decorated to high standards and people's rooms were furnished to their taste.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity
• People we spoke with told us staff were generally kind and caring, some better than others. People told us they had their privacy and dignity respected and closed doors and covered them up when delivering personal care.
• Some staff we were told chatted a bit but not always, depending on who it was. People told us staff knocked on their doors before entering. However, we observed an agency member of staff not doing this.
• People who were dependent on staff said they got up and went to bed when staff came around to do it. However, nobody complained about this. One person said, "It's just how it works here."

Supporting people to express their views and be involved in making decisions about their care
• We did not see that people and their relatives had been involved in care planning. However, we saw people were encouraged to make decisions about their day to day routines and express their personal preferences.

Respecting and promoting people's privacy, dignity and independence
• People were encouraged to be independent and do as much as they could for themselves. However, care plans did not always contain enough detail so that independence could be promoted. Guidance was not always available about what people could do for themselves or what they required support with.
• Relatives were able to visit without restrictions. People were able to maintain relationships with those close to them.
• Confidential information was not always stored securely. We saw daily notes left unattended in some of the units we visited. We brought this to the attention of the manager who told us this would be addressed.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant people's needs were not always met.

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

• Not all care plans included information about people's preferences and life history. Information was mainly task based. Some sections of care plans were blank and did not contain vital information such as mobility abilities, catheter management and information relating to skin lesions and pressure sores.

We saw one person was having puréed foods. However, no reference was made to this in the person's care plan.

• This meant staff did not have access to all the information they needed to meet people's needs and support them effectively which put people at potential risk of receiving unsafe or inappropriate care.

The interim manager was aware care plans needed reviewing and rewriting.

•There were no records of people with skin tears and pressure sores despite a community nurse who was visiting the service telling us they had received a lot of referrals for skin tears.

• We spoke with the community nurse about the level of care at the service. They told us they were not sure how one particular person had so many skin tears as they did not get out of bed. We asked staff about the persons skin tears and they told us it was because the person had frail skin. We did not see any reference to this in the person's care plan.

• One relative told us, the community nurse had been in recently as their family member had pressure sores. The relative told us it would depend on who was on duty as to whether she would ask how their relatives pressure sores were.

Records were not accurate complete and contemporaneous in relation to care delivery. This was a breach of regulation 17 (Good governance) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs; 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

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

• Care plans did not provide information about people's sensory or hearing impairments. One care plan we

viewed documented the person was registered blind. However, no further information was available relating to how staff supported the person to access information relating to the service. In addition, people with hearing impairments had no further information relating to communication needs recorded in their care plans to ensure that they were supported to understand information and communicate effectively with staff.
• We spoke with the activity's coordinator. They told us their activity programme had been changed by another 'lifestyle coordinator' in their absence without any consultation. The activity coordinator explained to us that people all liked the original programme and knew the days it was on, but nobody knew what was going on now.

The provider did not ensure people who used the service received person-centred care that was appropriate and met their needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We saw people attending a coffee morning in the main foyer on the second day of our inspection. We were told this was a regular event.
• Community events took place in the service on a regular basis such as coffee mornings and local schools visiting.

Improving care quality in response to complaints or concerns
• We saw that complaints had been responded to and action taken in a timely manner. People told us they would tell the office staff if there were any concerns and they were usually dealt with.

• End of life care and support
• The service supported people at the end of their life. One person was receiving end of life care during our inspection. We were told the palliative care team were available for support when required.
• Staff had not received end of life training. We viewed the person's care plan and saw this was without any specific information relating to how the person wanted to spend their day. In addition, the person's care plan did not include any information relating to their life history. The service had not considered people's individual values and beliefs and how these may influence end of life care.
• We visited the person in their room and they appeared comfortable and pain free. An air mattress was in place and drinks available.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider failed to ensure that there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) 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 had had several changes of management since our last inspection in 2018. At the time of our inspection there was no registered manager in post.
• People we spoke with told us about their uncertainty around the management of the service but did not think it would impact too much on their family member's health.
• The provider had an interim manager in place at the time of our inspection from one of the provider's other services. The interim manager was aware of our concerns and had started to address the issues we raised. However, we have received further concerns about the service since the time of our inspection visit.
• We received information following our inspection of poor practice which occurred on 1 August 2019. However, we were not informed about this until 20 September 2019 one day after our inspection.
• Although the provider had a governance system in place this had not worked effectively to identify any shortfalls and make improvements to the service. This had put people at risk of receiving poor care. The systems in place had also failed to ensure that people's care records were kept up to date and accurately reflected their needs and the support they required.
Quality monitoring systems were ineffective and did not ensure that the service operated safely. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
• The provider had recently had a significant change in their senior leadership team. The provider informed us they were committed to driving improvements across the organisation. Prior to our inspection the provider had identified a number of concerns at Icknield Court and had an action plan for improvement. At the time of our inspection it was too early to see whether this action plan was effective in driving improvements.
• The provider had placed a voluntary embargo on the service so that improvements could be achieved

before any further admissions were made to the service.
• Staff comments demonstrated a culture of low morale. For example, one staff member told us they did not know what was happening. Another thought the service was closing down. Other members of staff told us they were 'at rock bottom' and one member of staff said people were receiving poor care. This comment was relayed to the compliance officer for the service during the second day of our inspection for them to follow up.
• People said they did not know who was in charge and did not know if the home was well led or not.
• We observed there were no senior staff managing any of the units. During our inspection we found the ratio of agency staff on shift was high. One member of agency staff told us they could not assist a person because they did not know them. Care was disorganised, and unsafe, poor medicine administration and risk management meant people were at potential risk of harm, some staff said they did not know people's needs. We raised concerns with the provider regarding the safe care and treatment of people using the service at the time of the inspection.
• The provider was receptive to our concerns. We requested an action plan regarding the management of the units. This was sent to us the day after our inspection. The provider confirmed senior staff from one of the provider's other services would manage the units until improvements had been made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• People's health needs were met by a range of healthcare professionals. Including community nurses, the local GP and social workers.
People we spoke with told us they had not attended any residents or relatives' meetings. We did not see a feedback poster displayed for people and relatives to leave their comments.

Continuous learning and improving care
•Staff had not had opportunities for additional training and had not received regular supervisions to ensure they were supported in their roles effectively. Following our inspection the provider informed us additional training had been sourced for staff to attend.
• We saw that staff meetings took place sporadically to discuss issues and concerns.
• Staff felt discontented and said when they raised issues or concerns this was dismissed.
• Handovers took place during the change of shifts. We attended a handover on the second day of our inspection. The information relayed was insufficient and staff who attended the handover had not taken any form of notes to enable them to refer to this information throughout their shift. We discussed this with the compliance officer following the handover. They told us this would be looked into and addressed with immediate effect.

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
• We saw that the provider was aware of their responsibilities around the duty of candour. Apologies were made when things went wrong.

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 Service users did not receive person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received regular training to ensure they were competent in their role and to enable people's needs to be met.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Some people had not received their medicines due to lack of stock. Risk assessments were not in place for identified risks.

The enforcement action we took:

To issue a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the quality of the service were not effective which meant people were at risk of receiving a poor service.

The enforcement action we took:

To issue a warning notice