3A Care (Bromsgrove) Ltd

Regents Court Care Home

Inspection report

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06 December 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Regents Court Care Home is a residential care home providing personal care to up to 40 people. The service provides support to people over the age of 65 and people living with dementia. At the time of our inspection there were 33 people using the service.

People's experience of the service and what we found:
We found evidence during our inspection of multiple breaches of regulation and the need for this provider to make improvements.

People were not always protected from the risk of harm; we found systems were not effective in reducing risks to people from incidents, the spread of infection or the environment. Systems in place to safeguard people from abuse were not robust and processes for learning lessons were not effective in driving improvements.

People's care plans and risk assessments were not robust to ensure safe care delivery. Care records were not always person-centred, accurate and up to date. People were not always supported to access information in an appropriate way for their needs.

Staff recruitment practices and monitoring systems were not always effective to ensure safe care delivery. Staff were not always fully trained, or their understanding and competence checked to ensure they had understood the training and applied this to their practice. Training provided for staff was not meeting their role expectations and some staff's understanding of the Mental Capacity Act (2005) and dementia was limited.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. Staff did not have regular formal supervision to receive feedback on their performance, or constructive feedback on how this might be improved. People's health appointments and outcomes were not always recorded fully or accurately. This meant there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were.

People were not always 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 supported this practice. Systems and processes were not in place to effectively support people in the decision-making process.

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

Rating at last inspection and update

The last rating for this service was Requires Improvement (published 11 January 2023). 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
When we last inspected Regents Court Care Home on 16 & 17 November 2022, breaches of legal requirements were found. This inspection was undertaken to check whether they were now meeting the legal requirements.

During the inspection we also found there were concerns relating to how the provider had managed people's changing needs, so we widened the scope of the inspection to become a comprehensive 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 Regents Court Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people not being treated with dignity and respect, how people's safety was managed, how people were safeguarded from abuse, people's person-centred needs and how the service was run at this inspection.

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

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

Regents Court Care Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of 2 inspectors on all 4 visits to the home.

Service and service type
Regents Court 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. Regents Court is a care home without nursing care. 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
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all this information to plan our inspection.

During the inspection
We spoke to 12 people and 2 relatives about their experience of the care provided. We spoke with 3 professionals who have contact with the service. 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 23 members of staff including the nominated individual, director, registered manager, supporting managers, office managers, senior care staff, care staff, housekeeping, maintenance, laundry and activities members of staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 6 people's full care plans, daily monitoring charts for 18 people, medicine administration records (MAR) for 8 people and 4 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems.

We met with the nominated individual remotely over video call and face to face to share our feedback and concerns. The nominated individual developed an action plan and shared this with us at regular intervals.

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. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
- People were not safeguarded from the risk of abuse and avoidable harm.
- We found several incidents of potential abuse had not been reviewed, investigated and, where appropriate, reported to external agencies. For example, we reviewed incident records where people had unexplained bruising and staff had been accused of sleeping during their night shifts. No actions had been taken to safeguard those people. This put people at risk of ongoing abuse.

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

The provider took immediate steps to reduce the risk of harm to people, following our feedback.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;
- The provider did not assess risks to ensure people were safe. Staff did not take action to mitigate any identified risks.
- People's health needs and associated risks were not safely managed. For example, people who required support with catheter care, epilepsy or weight loss did not have specific, detailed, care plans in place. In addition, there was no system for recording and monitoring people's epileptic seizures. Staff were not always knowledgeable about managing these risks.
- People who were distressed were not supported safely. We found some people were experiencing an escalation in incidents of distress. However, care plans did not always give clear guidance to staff and there was no system for recording and reviewing these incidents. Staff were not always clear on how to deescalate people's distress. This put people, staff and relatives at risk of harm.
- The environment was not monitored effectively to reduce risks to people's safety. We observed people's bedroom doors were routinely propped open by staff. This meant that fire doors would not all automatically close in the event of the fire alarm being activated, which could lead to the spread of fire in the building.
- The provider did not learn lessons when things had gone wrong.
- There was no clear system for recording and reviewing accidents and incidents. Staff were unsure where such matters should be recorded. As a result, there was no opportunity to review incidents to identify trends and take action to reduce ongoing risks. This put people at risk of harm.

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

The provider took immediate steps to reduce the risk of harm to people, following our feedback.

Staffing and recruitment
● The provider did not operate safe recruitment processes.
● When we looked at the staff recruitment files, we found information missing. For example, not all staff files had interview notes in them, full employment histories, staff references and the latest information regarding staff visas and Disclosure and Barring Service (DBS) check numbers. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● People did not always receive the support they required to keep them safe. Staff told us staff who supported people at night were found sleeping. This had not been adequately investigated by the registered manager.
● The provider did not ensure there were sufficient numbers of suitably trained staff on each shift. We observed staff administering people's medicines without the appropriate training. This put people at risk of harm.
● Staff had not received appropriate training to assist them to deliver safe care and support. Staff told us they would welcome specialist dementia training, to help them to understand and better support people living with dementia.

Staff were not always safely recruited. This is a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection site visits the provider sent us copies of staff employment information and up-dated risk assessments as requested.

Using medicines safely; Preventing and controlling infection
● People were supported to receive their medicines in a way that was not always safe.
● We found evidence of medication administration errors by staff had not been effectively reviewed by the registered manager and were not reported to safeguarding.
● Not all staff administering medicines had the required training. This put people at risk of not receiving their medicines in line with their health needs.
● We observed people's medication administration records were not always completed in a timely manner, which put people at risk.
● People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices.
● People were not protected from hazards in the environment. We observed clutter throughout the home, such as broken furniture which could cause people to trip or fall. People also had access to storage areas which contained items that could harm them, such as chemicals or medical equipment.

Systems had not been established to monitor the administration of people's medicines and the safety of the environment. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate steps to reduce the risk of harm to people, following our feedback.

Visiting in Care Homes
People were able to receive visitors without restrictions in line with best practice guidance.

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 Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

- The provider did not work in line with the Mental Capacity Act.
- People's capacity to consent to decisions around their care and treatment was not always considered and, if required, assessed and documented.
- People's consent was not routinely sought by staff before carrying out care. We observed several examples of staff members carrying out a task without engaging with the person and seeking their consent first.
- We found the provider had requested DoLS assessments where appropriate but had not always updated the supervising body when people's needs had changed.

The provider had failed to systematically seek consent from people about their care and treatment. This was a breach of regulation 11 (Need for Consent) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
- The provider did not ensure the service worked effectively within and across organisations to deliver effective care, support and treatment.
- We found evidence people were not supported to access external health or social care in a timely manner. For example, 1 person had not been supported to access mental health support, despite their presentation changing.
- People were not always supported to eat and drink enough to maintain a balanced diet.
- Mealtimes were not always a positive experience for people. We observed staff focusing on tasks rather

than engaging with people. Some people who required support with their meals had to wait a long time for staff to help them.
● Where people were at risk of malnutrition or dehydration, systems were not in place to monitor intake and request external support as necessary.
● Health professionals shared concerns with us in relation to people being laid on the floor for extended periods without support following a fall and staff arguing.

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

Staff support: induction, training, skills and experience
● The service did not ensure staff had the skills, knowledge and experience to deliver effective care and support. There were no systems in place to monitor staff attendance at training courses.
● Records showed around a third of the staff team had not completed current training in core subjects such as infection control, fire safety and moving and handling. Following the inspection, the provider took action to which included sourcing additional specialist dementia awareness training and ensuring the staff team had received refresher training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not assessed, care and support was not delivered in line with current standards. People did not achieve effective outcomes.
● We were not assured that people's care records reflected their current care needs. Paperwork was stored in numerous places and staff were not always aware of people's care needs or where to look to find the relevant information.
● People's care plans lacked detail about their specific needs and how to mitigate any associated risks. For example, 1 person's care plan consisted of a list of complex medical conditions, with no further information about how these impacted the person or what support they needed to manage them.

Adapting service, design, decoration to meet people's needs
● People's individual needs were not always met by the adaption, design and decoration of the premises.
● The physical environment had not been adapted to take into consideration the needs to people living with dementia and there was a lack of signage in place to support people to navigate around the home. There were limited signs to help people recognise their own rooms. This meant people could not easily orientate themselves within the home. In addition, there was a lack of interactive or dementia-friendly resources within the home.
● People had access to lounge areas, dining rooms and if they wished for some quiet space, there was a small area people could use.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always well supported and treated with respect by staff.
- We were not assured that people were receiving person centred care from staff who knew their choices and preferences well.
- People told us staff weren't able to spend quality time with them. One person said, "They [staff] help me with the basics, but I feel like I'm taking their time up and they rush".
- People's privacy, dignity and independence were not always respected and promoted. One person told us, "I'd like to go out more, but there isn't someone available to help me do this."

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

- People were not always supported to express their views and make decisions about their care. One person told us, "I'm not asked for my opinion about things, it just is what it is".
- Records were not available to demonstrate that people's care plans were regularly reviewed with people to reflect their wishes and changing needs.
- There wasn't a system in place to gather and act on people's feedback.

Requires Improvement

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 Good. At this inspection the rating has changed to Requires Improvement. 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

- People were not always supported as individuals, or in line with their needs and preferences.
- We found limited evidence of regular care planning reviews with people and their relatives. For example, where people's needs had changed, care plans were not updated in a timely manner to ensure staff had the information they needed to meet people's needs.
- People spent long periods alone, without engagement. Records did not evidence people's preferences and wishes in relation to activities and support. One person told us, "I don't really like the activities on offer, so I tend to spend my time alone. But [activities coordinator] is lovely though and they spend time with me in my room when they have time".

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.

- The provider was not meeting the Accessible Information Standard.
- People's communication needs were not always understood and supported.
- People's information and communication needs had not been explored with them, recorded or communicated to staff to promote effective communication. This posed a risk people may feel isolated.
- The provider did not offer information such as care plans in alternative accessible formats to ensure people, including those living with dementia, had information they could access and understand. This increased the risk of poorer outcomes for people.

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 maintain relationships, follow their interests, or take part in activities that were relevant to them.
- People were not always supported to follow their interests, for example some people expressed a wish to go outside into the garden for some fresh air, but staff told us, and we saw, there were not enough staff to enable people to do this safely.
- However, we did observe the activities coordinator supporting individual people out into the community and to attend activities in the local community.
- People were supported with activities inside the home, for example an external exercise coach had visited,

and people told us they had enjoyed this.

Improving care quality in response to complaints or concerns

● People's concerns and complaints were not always listened to, responded to and used to improve the quality of care.

● People and relatives we spoke with told us they knew how to raise a complaint if they needed to but most were not aware who the manager was. One relative told us they had not received a response to their last complaint.

● Staff told us they had raised concerns with the registered manager, but no action had been taken. We raised this with the provider in feedback and action was taken to ensure all staff were given the opportunity to have supervision and their concerns addressed.

End of life care and support

● People did not always have an end-of-life care plans in place, and these lacked details about their preferences and wishes. The lack of details meant staff may not have the guidance they needed to promote good, person centred care for people at this key stage of their lives.

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 Good. At this inspection the rating has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection we found people did not receive a service that was well-led. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There wasn't enough improvement made at this inspection and the provider continued to be in breach of Regulation 17.

- Robust quality assurance processes were not in place to support the care provision. There wasn't a log for actions/ improvement required from the audits.
- Documentation provided to us showed that the audits were not completed regularly and/or thoroughly. This resulted in the provider failing to identify and/or take appropriate action to address a number of issues we found during this inspection that related to people's care records, medicines management and staff support.
- The provider did not have an effective management structure and did not monitor the quality of care provided in order to drive improvements.
- Systems and processes were not effective in ensuring incidents of harm, neglect or abuse were recorded, reviewed, investigated and, where appropriate, reported to external agencies.
- Governance systems failed to ensure people were not unlawfully deprived of their liberty by adhering to the conditions stipulated on authorisations and applying for new authorisations in a timely manner.
- The provider failed to maintain oversight of the culture of the home and the experiences of people, to ensure caring, person-centred, and compassionate care was received by people.
- Systems were not effective in ensuring people's consent was sought for all aspects of their care and treatment.

We found no evidence that people had been harmed however, there was a risk that people might not receive safe care from the provider who was not appropriately monitoring the care delivery and acting on issues identified. This was a 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; 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
●There was not a positive and open culture at the service.
●The provider did not have a system to provide person-centred care that achieved good outcomes for people.
● The culture of the service was not always aimed at valuing people's individuality and protecting their right to choice.
● The provider had failed to embed their policies and procedures so that staff were provided with robust guidance to ensure they provided people with person-centred care.
● The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour providers must be open and transparent if things go wrong with care and treatment. During the inspection we found the management team had not taken appropriate steps to identify and/or act upon the issues identified which meant they were not aware of their responsibilities under the Duty of Candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● People and staff were not involved in the running of the service and their protected characteristics were not well understood.
● The provider had not created a learning culture at the service, so people's care was not improved.
● Systems for continuous learning and improving people's care were not effective. For example, there were no audits undertaken to review the number of people with weight loss each month. Opportunities to drive through improvements in people's care were missed/not always taken.
● Staff did not have regular supervision, to receive feedback on their performance and constructive feedback on how this might be improved. Some staff told us there was a lack of clear communication and guidance from the management team.
● Systems for working effectively with other organisations with responsibilities for people's care were not always embedded. People's health appointments and outcomes were not always recorded fully or accurately. This meant that there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were.
● We found there were occasions where the provider had not requested external health and social care professionals' advice and support despite a deterioration in people's care needs.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect. This included a failure to systematically seek consent from people about their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to systematically seek consent from people about their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to effectively assess and document people's needs and manage associated risks. This put people at risk of harm.

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 The provider failed to effectively investigate, and take action to prevent, any allegation or evidence of abuse. This put people at risk of abuse or improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance, including assurance and auditing systems and processes. They failed to assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of people's experience.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was not taking adequate steps to ensure fit and proper persons were employed.