The Oaks (Spring) Limited

The Oaks

Inspection report

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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
The Oaks is a residential care home providing personal and nursing care to up to 113 people. The service provides support to older people, people living with dementia and people with mental health needs. At the time of our inspection there were 90 people using the service.

People's experience of the service and what we found
People were placed at undue risk of harm. Many people were unable to easily call staff for assistance when they needed it. Risk management plans were not always followed correctly to mitigate the risk of harm of skin breakdown. People's medicines were not managed safely. The service did not always follow good infection control procedures. There were maintenance issues of the building that had not been resolved or made safe.

People's hydration needs were not always met and the risk of dehydration was not properly mitigated. The risks associated with health conditions were not always assessed and care plans lacked sufficient guidance for staff. Staff did not receive the necessary training they needed to meet all the needs of people using the service. The building was not designed or adapted to fully meet the needs of people with dementia.

Due to the issues we found with the delivery of person-centred care we could not be assured people were always supported to have maximum choice and control of their lives.

Not everyone received a kind and caring service. We observed some poor, uncaring interactions between people and staff. People's dignity was not always maintained. Mealtimes were not well organised to ensure they were a calm and pleasurable experience. Food choices were not always presented in a way that would ensure people with cognitive decline could have as much choice and control as possible. We received mixed feedback from people and their relatives about the care they received.

Care plans did not contain sufficient information about people's personal history, interests or hobbies. People were not always provided with adequate stimulation and activities. People were not always supported to plan their end of life wishes. The provider was following their complaints process when people raised concerns about the quality of the care they received.

The provider had made some improvements to the service but further improvements were needed to ensure people received a safe and effective service. The provider did not always carry out investigations when things went wrong and lessons were not always learnt from previous incidents. There were a wide range of quality assurance checks taking place but many of these had not been effective and had not resolved issues in a timely manner. In general staff were positive about the culture of the organisation and were happy with the support they received from the senior managers. However, feedback indicated not all members of staff were working to ensure people always received high standards of care. The provider acknowledged the issues we identified during the inspection and started making improvements immediately after the

inspection.

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 the service under the previous provider was Good (published on 18 November 2020).

Why we inspected
The inspection was prompted in part due to concerns we received about safe care and treatment, the management of medicines and person-centred care. A decision was made for us to inspect and examine those risks. As this is the first inspection of the service under the new provider we carried out a comprehensive inspection.

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

Enforcement
We have identified breaches in relation to nutrition and hydration, person-centred care, safe care and treatment, staff training and good governance.

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

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

The Oaks

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, a medicines inspector, a nurse specialist advisor and 2 Experts by Experience. 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
The Oaks 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. The Oaks is a care home with 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 not a registered manager in post. There was a general manager who was in the process of applying to be registered. We have since been informed the general manager has resigned from their post.

Notice of inspection
The first day of the inspection was unannounced. The provider knew we would be returning to continue the inspection on subsequent days.

What we did before the inspection
We used the information the provider sent us in the Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the most recent Healthwatch report for the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We looked at a range of records including 20 people's medicine and care records and 6 staff files in relation to recruitment, induction and supervision. We also looked at training records and records related to the management of the service which included, accident and incidents, complaints and quality assurance records and audits.

We spoke with 10 people and 5 relatives of people receiving care to get their views of the service provided. We also spoke with 13 members of staff including 4 health care assistants, 4 nurses/unit managers, the chef, the activities coordinator, the general home manager, the deputy manager, the regional manager and the clinical project manager. After the inspection we sent feedback questionnaires to staff to get their experience of working at the service. We received 5 responses. We also made calls to a further 10 relatives of people receiving care.

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

Assessing risk, safety monitoring and management

- The provider failed to ensure risks to people were consistently and safely managed. Staff did not always take action to mitigate all identified risks.
- The risk of developing pressure sores was not being adequately mitigated. Many people were at increased risk due to complex health needs, low mobility and being cared for in bed. Staff carried out risk assessments and developed care plans to mitigate the risks, however these were not being followed. Many people required staff to reposition them at regular intervals to reduce the risk of skin breakdown, but this was not happening and people were spending many hours in bed with no record of being supported to change position. This placed people at risk of developing pressure ulcers.
- The provider did not ensure people could summon help or assistance when they needed it. We observed many people's call bells were out of reach and care plans contained conflicting information about people's ability to use the call bell to summon help. When people used their call bell staff did not always respond immediately. We observed several staff disregarding the call bell during the inspection when someone needed assistance. A relative also told us, "There was a time we pressed the buzzer and it took them an hour to come."
- Unresolved maintenance issues posed a risk to people's health and wellbeing. An external door on the ground floor was rotten exposing the edge of the pane of glass within the door frame. Routine maintenance checks had first identified this issue in March 2023 and again in May 2023, but the door had not been replaced or made safe and remained a hazard to people using the service at the time of the inspection.
- During the inspection we saw many linen cupboards and cupboards containing hazardous cleaning products were left unlocked and unattended which exposed people to the risk of harm.

The failure to mitigate the risks to people's health and wellbeing was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People were placed at risk of ill health by not receiving their medicines in line with prescriber's directions and national guidance.
- There was no formal process in place to ensure time-sensitive medicines were being given on time or with an appropriate gap between doses. One person had missed doses of their Parkinson's medicines as the directions for the timed doses was not in place and staff and had not been identified by staff.
- The process for the stock management of medicines was not robust. Staff were not consistently completing daily stock checks to ensure medicines were always available. These failures meant people sometimes went without their prescribed medicines when their stock of medicines had run out.
- Medicine administration records (MARs) were not completed correctly and/or in line with national

guidance. There were some unexplained gaps on the MAR charts where staff had not signed so we could not be assured that people were always receiving their medicines as prescribed. Hand-written MARs had not been checked for accuracy by another member of staff.

● ' When required' medicine instructions for staff were not always accurate and did not provide enough personalised information for staff to understand how to meet people's care needs.

● Where people were prescribed 'when required' medicines to help with anxiety and agitation staff did not always record the reason for giving it and entries on the daily notes indicated people were often not anxious or agitated when these medicines had been administered. This meant we could not be assured staff were adhering to the prescriber's directions.

● The administration of topical creams was not being recorded or in line with agreed guidelines. Some people were prescribed patches which are applied to the skin to deliver pain relief medicine to alleviate chronic pain. The removal of the patch was not always recorded. When it was recorded 2 members of staff did not witness the removal and patches were not checked daily to ensure they remained in place. Staff also did not record when they had administered topical creams. The failure to check the patch daily according to guidance placed people at risk of not receiving the pain relief they required.

● We could not be assured medicines were being stored at the correct temperature as we found temperature records showed medicine storage areas exceeded recommended maximum temperature levels on numerous occasions. The failure to ensure medicines were stored at the correct temperature placed people at risk of worsening ill-health from medicines that were no longer stable or effective.

This failure to manage people's medicines safely put people at risk of harm and was further evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not always protected from the risk of infection as staff were not always following safe infection prevention and control practices.

● Staff did not always carry out safe hand hygiene practices when administering medicines. People receiving care were not supported to carry out hand hygiene before mealtimes in accordance with the provider's own guidelines.

● Infection control audits were carried out but they were not always effective as we found some communal areas and equipment were not cleaned to a high standard. Cleaning checklists were not always completed and/or reviewed by managers.

● We saw dairy food items were not always stored in the fridges immediately which meant they were being stored in a warm room for an indeterminate length of time. We also found fridges contained food and drinks which had not been labelled when opened. These oversights placed people at increased risk of consuming food that was not safe to eat.

● Two clinical rooms had leaks in the air conditioning units which meant water was actively leaking into areas where medicines and nutritional supplements were being stored.

The failure to prevent and control the risk of infection was as a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and avoidable harm; Learning lessons when things go wrong

● People were not always safeguarded from abuse and avoidable harm and the provider did not always learn lessons when things had gone wrong. There had been several similar allegations of poor care at the service. Most incidents had been fully investigated and recommendations made to prevent reoccurrence of similar events. Despite this we observed continued issues of a similar nature which showed learning had not

been embedded within the service.
● We also saw examples of incidents which had not been investigated to identify the cause. This meant we could not be assured the provider was ensuring people were protected from the risk of abuse and avoidable harm.
● Staff received appropriate training and showed a good understanding of what to do if they observed abuse or neglect. One member of staff told us, "I would report immediately through the whistleblowing channel provided by the company or report to the CQC." However, due to the multiple issues we found we could not be assured staff were following the guidance and reporting all concerns and incidents of poor care.

Staffing and recruitment
● The provider did not always operate safe recruitment processes, as they had not obtained a full employment history when recruiting new staff. We raised this with the nominated individual and they took action to resolve the gaps in staff employment histories.
● The provider checked candidates' right to work in the UK, obtained references from previous employers and carried out Disclosure and Barring Service (DBS) checks. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.
● The provider ensured there were sufficient numbers of suitable staff. Many people required 1-2-1 support due to distressed behaviours and rotas were planned to ensure they received support in line with this. Although we did not identify issues with staffing levels, we received mixed feedback from people. One person told us, "Sometimes it's very good and sometimes there's not enough."

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

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People were not supported to drink enough fluid to maintain good health. The risk of dehydration was not being managed safely for people unable to manage their own fluid intake.
- Many people did not have any fluid within reach and were not being supported to take adequate fluids. Fluid recording charts for people at risk of dehydration were not being completed consistently to ensure people reached their fluid targets.
- One person's care plan stated they had a daily fluid target of 1500ml. On the day of the inspection, we observed they had fluids in reach but had not drunk anything by 1.30pm and there were no fluids recorded on their fluid chart. When the nurse asked the person what they had to drink they could not remember when they last had something to drink which indicated they were at risk of dehydration.
- We saw several other people who did not have any drink within reach and fluid charts showed they were often not meeting their fluid targets. The failure to ensure people's fluids were managed in line with their assessed needs placed people at risk of dehydration and ill-health.

The failure to ensure people's hydration needs were being met placed people at risk of poor health from dehydration and was a breach of regulation 14 (Meeting nutritional and hydration needs) 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

- The provider did not always ensure the service worked effectively within and across organisations to deliver effective care, support and treatment. People were not always supported to access healthcare services and support in a timely way.
- Guidance for the management of diabetes was not sufficient. One person was living with diabetes and staff were recording their blood glucose levels, however, there was no guidance in place about what the blood glucose range should be for this person. Care records showed staff had failed to inform the GP or liaise with diabetic care teams when their blood glucose levels were fluctuating greatly. This placed them at risk of harm through poor management of their diabetes.
- Information about people's health conditions such as epilepsy was not sufficient to ensure staff had a good understanding of the type and nature of people's seizures or knew what to do if the person had a seizure. The lack of information and poor guidance placed people at risk of harm whilst having a seizure.
- One person was living with an organ transplant but there was no information about how this affected them or any specific lifestyle guidance on how to stay healthy. The lack of guidance for staff placed them at

risk of ill health.

The failure to manage the risks associated with people's health conditions was as a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The service did not always make sure staff had the skills and knowledge to deliver effective care and support. Although there was a broad range of training being provided staff did not always receive training to meet all the needs of all people using the service.
● Staff did not receive mental health training despite the service specialising in providing care to people with mental health needs.
● There was also no epilepsy or diabetes training provided and we identified several people were living with those conditions. The lack of specific training and insufficient guidance in care records exposed people to the risk of being cared for by staff that did not have the skills and knowledge to meet their needs safely.

The failure to ensure there were sufficient suitably qualified staff on duty at all times was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the gaps in training most staff told us they felt they received adequate training and support from managers to enable them to carry out their role. One member of staff told us, "We have lots of different training here. Some online and some face-to-face."
● Staff told us and records confirmed staff received regular supervision and an appraisal. We saw follow-up supervision was carried out when staff performance issues were identified.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always fully assessed before entering the service and care plans were not always written as soon as people entered the service.
● The provider had stopped conducting face-to-face assessments before people moved into the service due to covid-19. This meant some people's needs were not fully understood until after they moved to the service and the provider could not be assured they were able to fully meet people's needs. After the inspection the provider has told us that they have identified several people who they believe were not suitable for the service as staff who had carried out initial assessments did not fully understand all their health and social care needs.
● The provider is working with people receiving care, family members and commissioners to find more appropriate placements. The provider has also informed us they have now re-implemented in-person preadmission assessments to enable staff to undertake adequate assessments and develop immediate care support plans.

Adapting service, design, decoration to meet people's needs
● People's individual needs were not met by the adaption, design and decoration of the premises.
The service was not purpose built and was not adapted to meet the needs of people with dementia. The design and layout of the building was not easy to navigate and not enough had been done to improve this.
● Each room had a recent picture of the occupant outside to help people identify their room. However, many people with dementia would find it difficult to recognise themselves from a recent picture. Memory boxes had been in place outside of people's rooms but these had been removed.
● Many rooms had not been personalised in accordance with people's taste and lacked personal effects or belongings. One family member told us, "It hasn't been decorated since she's been there, but they did say they would paint it."

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).

- Staff told us how they obtained people's consent before providing care and support.
- The provider conducted mental capacity assessments when they had reason to believe people could not consent to their care and support.
- DoLS assessments were completed by the local authority and an authorisation granted if agreed. Staff ensured people were cared for in line with the authorisation, so people had the least restrictive care.

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
- People were not always well supported and treated with respect by staff. We observed examples of indifferent, uncaring interactions between staff and people receiving care. Some people were getting 1-2-1 support due to distressed behaviours, yet the staff providing the support did not always interact with people or keep them stimulated.
- People's protected characteristics such as sexuality were not always recorded. Care plans contained confusing or irrelevant statements about people's sexuality needs. We could not be assured people's needs were fully understood.
- We received mixed feedback from people about the kind and caring approach of staff which indicated people were not always treated with kindness and compassion. Positive comments included, "The staff are lovely" and "All the staff are very respectful."
- Despite positive feedback many people who were being cared for in bed told us staff did not spend time engaging with them. We received comments such as, "Staff never linger and sit with me" and "They are too busy."

The failure to ensure assessments included all of people's needs was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
- Mealtimes were not planned in a way to ensure they were a relaxed, pleasurable experience. On both days of the inspection the lunch service took a long time to be served and people had become visibly hungry and impatient due to sitting around waiting for a long time.
- People were not offered a choice of what to eat in a way they could understand. Visual aids displayed in the home were potentially confusing. For example lunch and teatime options were being displayed in the morning alongside the options for breakfast. This could potentially cause confusion for people with cognitive decline.
- Personal food preferences were either not recorded or care plans contained conflicting information. The chef also did not have a copy of people's preferences so we could not be assured menus were planned with personal preferences in mind.
- Table settings were not in line with current dementia service best practice and many people were not given the option of eating meals at a table and were served their meal in the chair they had been sat in before lunch.
- We received mixed feedback from people and staff about the quality of the food. One person told us, "Oh

it's lovely and they always ask [family member] what the wants and they read the menu. There's a variety of foods and they all know what [family member] likes." However, this was not everyone's experience. Negative comments included, "No effort is made to offer an alternative diet" and "I think there should be more options to choose from."

The failure to ensure food and drink provided met people's individual needs was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

● People were not always treated with dignity. We observed one person had been left in an undignified state which staff had not identified and/or resolved. When we raised this with staff we were told the person had known behaviours which compromised their dignity. The information about behaviours was not included in the person's care plan and there was no guidance for staff to ensure they took steps to ensure the person's dignity was maintained.

● During the lunchtime service we saw one person had dropped their plate of food on the floor and clearly needed assistance. Several staff came into the dining area but failed to notice the person needed support to enjoy their meal with dignity.

● Staff told us they understood how to ensure people's dignity and privacy was maintained when supporting people with personal care. One member of staff told us, "I ensure I support people's dignity by shutting the door and closing the blinds. I always try to find out what people can do for themselves."

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; 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 as individuals, or in line with their needs and preferences. Most people's care plans did not contain any information about their life story and/or likes and dislikes which would help staff understand them better.
- There was a monthly activities plan in place which showed a range of communal activities. However, due to the size of the service and the lack of personal information about people's hobbies or interests, we could not be assured the activities on offer really met people's needs, choices and personal preferences.
- Many people cared for in bed were not engaged or stimulated during the inspection. Activity coordinators provided communal and 1-2-1 activities. Very few people could engage with the group activities on offer and due the size of the service not everyone received individual input from an activity coordinator on a regular basis. Care records showed many people had very few opportunities of daily interaction beyond meeting their basic needs.
- We received mixed feedback from people and their relatives about the activities being provided. Several people told us they had, "Never seen any activities."
- Some people had some very positive experiences of the activities. Positive comments included, "They have 2 activity people and they do flower arranging which my mum loves." However, one person told us, "I have told them [family member] likes gardening and I have brought all the stuff, but they very rarely go out." The mixed feedback showed the provision of activities was not consistent and did not meet everyone's needs.
- Two people told us their television didn't work properly or the remote control required batteries, so they couldn't watch their television. A relative also told us, "I've just got [family member] a television for their room but very often it's switched off."

The failure to provide person centred care and ensure people's social needs were met was further evidence of a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 meeting the Accessible Information Standard. People's communication needs were understood and supported.
● Care plans contained information about people's communication needs, including aids or adaptations they used to support communication. We saw staff communicating with people in their first language.

End of life care and support
● At the time of the inspection the service was not supporting anyone who required end of life care. Records showed the provider worked with other professionals to ensure people were supported at the end of their life to have a comfortable, dignified and pain free death. Staff received training in end of life care to ensure they understood how to care for people.
● The service had not consulted people and their relatives to support them to devise a funeral plan which fulfilled their spiritual and cultural wishes.

Improving care quality in response to complaints or concerns
● There was a system in place to respond to complaints and concerns. People's complaints were listened to, and the provider took appropriate action to resolve things when people were dissatisfied with their care.
● We received generally positive comments about how the provider had responded when people complained about the care they received. Comments included, "We did have a few issues with the room and the manager has responded and [family member] has moved rooms, which is much better" and "We had some concerns but [the nominated individual] has gone above and beyond to sort things out."

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

- The service was not well managed. There was a system of audits and quality assurance checks taking place, but they were not effective, as they had not identified all the issues we found with care plans, risk assessments, medicines, infection control and fluid and repositioning records.
- The provider's processes failed to reduce or remove risks in a timely manner. The maintenance issues we found with clinical rooms and the broken door and not been resolved despite them being identified during routine maintenance checks of the service several months before the inspection.
- On the first day of the inspection we observed records related to people using the service were being stored in unsecured boxes in the communal corridor. This meant confidential records could be easily accessible to unauthorised people such as other people using the service or visiting members of the public. We raised our concerns about the storage of these records and the management confirmed that the files were in the process of being moved. It was not clear how long the records had been stored in this unsecured way. After we raised our concerns staff took immediate action to secure the files and have confirmed this was an isolated incident.

The failure to assess, monitor and improve the quality and safety of the services provided was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- The provider had not created a learning culture at the service, so people's care was not improved.
- Care plan audits that had been completed were not effective. When issues or shortfalls were identified there was often no actions put in place to ensure improvements would be made.
- The provider had not conducted investigations into all incidents to understand the cause, which would help prevent similar incidents from happening again. Where investigations had been carried out recommendations did not result in sustained improvements across the service.
- A recent investigation had identified staff had not been updating care records appropriately after delivering care. Although the individual staff members were given additional supervision to refresh their knowledge and understanding, we found this had not resulted in improved record keeping standards generally and we found consistent, ongoing issues with care records across the whole service.
- According to feedback we received from the local authority, visiting professionals and relatives of people receiving care, the provider had made some improvements since they took over the service. One person told

us, "Things have definitely got better. The managers are improving things and I feel more assured."
● Despite the generally positive feedback, our observations and the provider's own internal audits showed significant improvements were still required to ensure people received safe and effective care.
● We raised our concerns about the issues we found during the inspection and the provider immediately submitted an action plan which acknowledged the shortfalls we found and set out a plan to make improvements, which included revised systems and processes and additional staff training.

The failure to assess, monitor and improve the quality and safety of the services provided was further evidence of 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
● The provider did not operate effective systems and processes to ensure all people received person-centred care that achieved good outcomes. We received mixed feedback from people and their relatives about the care being delivered. Positive comments included, "I've been impressed with the way [family member] is being looked after" and "I've got no concerns. This is better than the previous placement."
● Not everyone's experience was so positive. One person told us, "Don't get me wrong, there are lots of people there who are great, but they need more people who actually care."
● Although staff were generally positive about the management some staff did not think all colleagues were able/committed to delivering high quality care and support. Comments from staff included, "We need more staff that can do their job" and "Some care staff have no experience and no patience to assist people."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were systems in place for people and their relatives to give feedback about the service. There were relatives' meetings to provide the opportunity to give feedback and share ideas for improvements.
● Relatives were also contacted for feedback when staff were reviewing people's care plans. One family member told us, "A member of staff phoned and asked me if I had any concerns because they were reviewing the plan as [family member] was resident of the day. I told them I had no concerns."
● Staff attended meetings to help them share information with colleagues and help drive improvements to the quality of care. One member of staff told us, "There are opportunities to raise issues and share ideas."

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

Working in partnership with others
● The provider did not always work in partnership with others. We saw some examples of good partnership working but this was not consistent across the service. Health concerns were not always referred to the appropriate health professional in good time.
● Some elements of partnership working were out of the provider's control. For example, the GP did not conduct regular visits to the service in order to support people to achieve good health outcomes. The local authority told us they would be looking to ensure the allocated GP offered regular visits to the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was failing to ensure people were supported to receive personalised care that met their needs and preferences. The provider did not always meet people's preferences and promote choice in relation to eating and drinking.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient numbers of suitably qualified and skilled staff were deployed to meet people's needs.

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
Treatment of disease, disorder or injury	The provider did not do all that was practicable to ensure that care and treatment was provided in a safe way as risks to people were not always identified and mitigated. Systems for the proper and safe management of medicines were not operated effectively.

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider failed to ensure people's nutrition and hydration needs were met.

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to assess, monitor and improve the quality and safety of the service effectively. The provider had failed to ensure people received a consistently safe and good service.

The enforcement action we took:

Issued warning notice