Caldwell & Beling Ltd

The Oaks Care Home

Inspection report

46 New Brighton Road
Emsworth
Hampshire
PO10 7QR

Tel: 01243372155

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Oaks Care Home is a residential care home providing personal care and accommodation in one adapted building for up to 33 people. At the time of our inspection there were 30 people using the service, all of who were over the age of 65 and some of which were living with dementia.

People's experience of using this service and what we found
Although people told us they felt safe we found that not all people's care plans, and risk assessments contained detailed information and clear guidance to staff about how people's needs should be met to mitigate risks. Therefore, we could not be assured people were being provided with safe care and treatment.

We could not be assured people were protected from abuse. The management team and staff lacked knowledge and understanding of what constituted safeguarding and effective processes for investigating safeguarding incidents were not followed.

Although there was processes in place to monitor incidents, accidents and near misses we could not be assured action to address issues was always taken when needed.

We observed sufficient numbers of staff available to meet people's needs in a person centred and timely way, however, staff recruitment systems were not followed robustly to help ensure only suitable staff were employed.

We could not be assured people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

Not all staff had received specific essential training and training had not always been received or renewed in a timely way.

People told us they were supported to access healthcare services when required. However, information relating to people's health needs was not always clearly documented within people's care plans and staff lacked understanding and awareness of these.

People received enough to eat and drink and told us they enjoyed the food.

Quality and safety monitoring systems were not adequate, and we found there was a lack of governance processes and systems in place to help ensure the safe running of the service. Without these systems, the provider and registered manager could not be proactive in identifying issues and concerns in a timely way and acting on these.

Environmental risks had been considered and acted on where required. Infection, prevention and control processes and up to date policies were in place. The provider, management and staff adhered to the latest government guidance in relation to infection, prevention and control.

People and relatives were happy with the care provided and spoke positively about the staff and running of the service. We observed some positive interactions between people and staff.

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 Good (published 3 May 2018).

Why we inspected
The inspection was prompted in part due to concerns received about, staffing levels, lack of staff training, environmental issues and poor management and leadership. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified seven breaches in relation to safe care and treatment, safeguarding, recruitment, staffing, consent, good governance and failure to notify at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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?

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Oaks 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.

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

Inspection team
The inspection team comprised three inspectors and an Expert 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 Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 3 November 2022 and ended on 21 November 2022. We visited the service on 3

November 2022.

What we did before the inspection
We reviewed the information we had received about the service, including the previous inspection report and notifications. Notifications are information about specific important events the service is legally required to send to us. 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.

During the inspection
We spoke with seven people who used the service about their experience of the care provided and six relatives. We received feedback from one healthcare professional. We also spoke with 16 members of staff including the provider who was also the nominated individual, registered manager, deputy manager, housekeepers, head of maintenance and 10 care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records, including seven people's care records in detail, and specific areas of 12 other people's records. Three staff files were reviewed in relation to recruitment. A variety of records relating to the management of the service, including audits, training, staff rota's, policies and procedures were also reviewed.

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

- Risks were not always managed and mitigated effectively.
- Although people told us they felt safe we found that not all people's care plans and risk assessments contained detailed information and clear guidance to staff about how people's needs should be met to mitigate risks. For example, we identified two people living at the home had Asthma, however, specific care plans or risk assessments in relation to the management of this were not in place. This meant no guidance was available to staff with actions they should take if this person's breathing became compromised.
- The service had completed assessment tools to establish specific risks to people. These tools provided a 'score' which indicated the level of risk to people in relation to specific areas such as skin integrity, constipation and choking. Although these had been completed, we were unable to establish if or what action had been taken when it was deemed a person was at high risk. No specific care plans or risk assessments had been developed following the completion of these. For example, some people living at the home were at high risk of skin damage or constipation yet detailed care plans or risk assessments in relation to the management of these were not in place. This meant no guidance was available to staff with what actions they should take to prevent and mitigate these risks.
- Two people were cared for in bed. This meant they were at high risk of developing pressure injuries. On review of one of these people's care records there was no information about the person's ability to change their position independently or the level of support they required. We discussed this with the registered manager who confirmed the person required full assistance from two staff to change their position and this support should be provided two hourly. The registered manager agreed to update the person's care plan and develop a risk assessment to reflect this. We reviewed the reposition records for this person and identified this person's position had not been changed as described by the registered manager. This meant the person was at significant risk of skin damage.
- One person had been identified as having a high risk of choking, by both the registered manager and speech and language therapists (SALT), yet this risk was not included in their care plan and a risk assessment was not in place. Therefore, we could not be assured staff were aware of this risk and had information available to them of what action to take to mitigate this risk.

The failure to ensure people were provided with safe care and treatment was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Environmental risks were monitored and managed.
- There were effective fire safety arrangements in place and fire risk assessments had been completed by a suitably qualified professional. Additionally, gas and electrical safety certificates were up to date and the service took appropriate action to reduce potential risks relating to Legionella disease.

● Equipment, including, hoists and lifts were serviced and checked regularly.
● Environmental risk assessments, general audit checks and health and safety audits were completed. Actions had been taken where highlighted, to help ensure the safety of the environment.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at The Oaks Care Home. People's comments included, "I have got my little room, I'm safe" and "Safe? oh yes. The staff are very good to me and very helpful. They're super." Relatives comments included, "It's a safe environment", "Yes [safe], they're very vigilant in managing her. There's an alarm by her bed in case she falls out" and "There's been no reason to worry."
● Although people told us they felt safe we could not be assured the management team and the staff knew what constituted safeguarding, understood their safeguarding responsibilities, knew how to report concerns or use effective processes for investigating safeguarding incidents to ensure people were protected from abuse.
● In the daily records for one person it stated, 'bruising on left shoulder and both knees.' There was no information available which demonstrated the cause of these bruises had been investigated or reported. For another person we noted they had sustained a serious injury whilst receiving care and support from staff. These incidents had not been investigated and no referrals had been made to the local safeguarding team. When asked about these, the registered manager told us they had no knowledge of these incidents. The failure to investigate and report these incidents meant people may not have been safeguarded from potential abuse.
● On review of the daily staff handover records we identified from the 27 October 2022 to the 8 November 2022 staff had recorded seven incidents of what staff described as 'Episode of challenging behaviour' for three specific people. Comments on these records included; 'high level intervention was required' and 'refused to stand and trying to put herself on the floor, took three carers to stand her.' Care records for all three people were reviewed and we established there were no care plans; risk assessments or detailed behaviour support plans in place detailing how staff should provide care and support appropriately. From the comments made within the daily records and handover documents we could not be assured these people were being supported in a kind way. These comments also indicated potential unlawful restraint and interventions being provided against people's view's and wishes. We discussed these record entries with the registered manager who told us, they felt the terminology used may not be the most appropriate. The registered manager also told us in relation to the person who refused to stand, a discussion had taken place with the person's relative and social care professional and a plan was put in place to 'strongly encourage and support' person's mobility in their best interest. This was not supported by a completed MCA assessment or best interest decision records.

The failure to report concerns and follow systems and procedures to keep people safe and protect them from abuse 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.

● Following the inspection, we reported these incidents to the local authority responsible for safeguarding matters. The management team offered us some reassurance all future incidents would be reported appropriately.

Staffing and recruitment
● Although there was a recruitment policy and processes in place, we could not be assured these were followed to ensure there was safe and effective recruitment procedures in place to help ensure only suitable staff were employed.
● We viewed recruitment records for three of the staff employed by the service and found recruitment

processes for new staff were not robust.
● The registered manager was unable to demonstrate disclosure and barring service (DBS) checks had been completed, for one member of staff before they commenced working at The Oaks Care Home. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.
● Of the three staff files reviewed we could not establish if all these staff had received an interview as records were not in place. When this was discussed with the registered manager, they informed us interviews were completed for all staff however, they were unable to provide evidence of this.
● Of the three records viewed we identified two staff had gaps in their employment history without a written explanation. This meant robust pre-employment checks were not completed.
● The recruitment issues found were discussed with the registered manager who acknowledged these shortfalls. The registered manager agreed to review the recruitment files and update them where required.

The failure to ensure the safe and appropriate recruitment practices were followed was a breach of Regulation 19 (Fit and proper persons employed)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives had mixed views on the staffing levels within the home, however most confirmed it did not impact on the care they received. A person told us, "They could do with a few more, they're rushed off their legs, but they're very good to me." Relatives comments included, "There's been changes of staff recently. They complement the regular staff with agency staff. I'm sure they would welcome more staff", "At the times we come in there always is [enough staff]" and "I came one day a couple of weeks ago and it was difficult to find staff."
● Although people and relatives had mixed views on the number of staff available, they all felt the staff were visible and responsive to people's needs in a timely way. A person said, "They come immediately when I need them." Another person told us, "You don't wait."
● During the inspection we observed staff were available to people and responsive to people's needs and requests for support. There was a relaxed atmosphere in the home and staff had time to chat to people and support them in a calm and unhurried way. Staff spoke to people with kindness and respect.
● Staffing levels were determined by the number of people using the service and the level of care they required. The registered manager kept staffing levels under review and used a formal assessment tool to determine the numbers of staff required to meet people's needs. The registered manager regularly monitored the staffing levels to help identify that staffing levels remained sufficient and people's needs were met in a timely way.
● Short term staff absences were covered by existing staff members and regular agency staff. This helped to ensure people had a consistent staff team.

Using medicines safely
● We could not be assured where people were prescribed topical medicines to prevent skin conditions, such as creams, lotions or ointments, these were consistently applied, as required. Care records and labels on tubs, tubes and bottles did not provide information as to when or how creams should be applied. Comments on these frequently stated, 'apply as directed.' However, no guidance was available to staff about what 'as directed' meant.
● We viewed topical creams stored in people's bedrooms and identified these were not always labelled with the date of opening or expiry, this meant staff would not know when to discard these as they would no longer be safe to use.
● We raised the above concerns with the management team who agreed they would review the processes in relation to the management of topical creams.

● The home used an electronic medicines management system. A staff member demonstrated this system and said this helped to ensure people always received their medicines correctly. On review of this system we could confirm people received their oral medicine, as prescribed.
● There were systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely.
● There were systems in place including daily and monthly checks to ensure medicine had been given as prescribed and to help ensure medicines were always available to people.
● Medicines that have legal controls, 'Controlled drugs' were appropriately and safely managed and monitored.

Learning lessons when things go wrong
● Although there was processes in place to monitor incidents, accidents and near misses we could not be assured action to address issues was always taken when needed.
● There was a lack of written evidence that lessons were learnt when things went wrong. For example, monthly falls audits completed did not demonstrate following a fall actions were considered or taken to prevent future falls. We discussed this with the registered manager who told us, they do consider themes and trends following falls and incidents, however, don't keep a record of this. The registered manager also explained occasions when changes to care or when new equipment was put in place following falls. This included a new type of cushion being sourced to prevent a person slipping from a chair and the purchasing of a 'laser beam' alert system to notify staff when a person was at risk of falling.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the latest government 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.

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 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.

- Some of the people living at The Oaks Care Home lacked the capacity to understand and consent to aspects of their care such as being administered medicines or receiving support with personal hygiene needs. Documentation did not consistently demonstrate people's mental capacity to consent to care or treatment had been appropriately recorded in line with legislation. Mental Capacity Assessments were unclear and were not always decision specific.
- Some people living at the home were provided with equipment which placed them under continuous supervision or restricted their movements. Equipment included the use of bed rails and alert mats; which would notify staff if a person moved. Decision specific mental capacity and best interest decisions for the use of this equipment had not been completed.
- We could not be assured the correct MCA procedures had been followed where people may require support with personal care. For example, we identified in one person's daily care records it described how the person was displaying aggressive behaviour during personal care intervention, and staff had noted they were 'working in the person's best interests.' However, there was no MCA assessment or best interest decision in place to support this staff practice.
- For another person we identified within their daily records, '[Name of person] refused to stand, took three carers to stand her.' The need for three carers to assist this person to mobilise was not documented within any of the persons care records which highlighted the normal mobility for this person was assistance from one staff member. We discussed this with a member of the management team who told us no decision

specific mental capacity assessment followed by a best interest decision had been completed for the provision of personal care for this person who lacked the capacity to make decisions about their personal care needs.

● Although, during the inspection site visit we observed staff seeking people's verbal consent in a kind and caring way before assisting them, from the review of the records and discussions with the staff and management we could not be assured people's human rights were protected in line with the MCA.

● We could not be assured the management team understood their responsibilities in terms of making applications for deprivation of liberty safeguards (DoLS) as required, as DoLS applications made had only considered the service having a locked door.

● Not all staff had received training in relation to the MCA and it was clear both the management team and staff lacked knowledge and understanding in relation to this. Immediately following the site visit the registered manager sourced additional training on this subject.

The lack of assessing people's capacity and having regard of the Mental Capacity Act was a breach of Regulation 11 (Need for consent) of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● We could not be assured staff received an effective induction or appropriate training to provide them with the skills required to support people effectively and safely.

● Induction processes were in place however, on review of these they were not robustly followed or completed. For example, for one staff member the checklist indicated the staff member had completed the induction training, when in fact, they had just been made aware they should complete the training. For another staff member, the induction checklist had been signed as all training had been completed however, this could not be supported by training records. We discussed this with a member of the management team who told us they were in the process of introducing a system whereby staff should complete the training before their start date.

● The provider's training records showed that staff had not received adequate training in a timely way to equip them to do their roles, safely and effectively.

● We were told by the management team that eight of the staff working at the home were responsible for the administration of medicines. On review of these staff members training records we identified only three of these staff had completed medicine training.

● On review of the training records we identified not all staff had received specific essential training and training had not always been received or renewed in a timely way. For example, the training record for one member of staff who had worked at the service as a member of the care team for five months showed they had not received training in moving and positioning, MCA, infection control and safeguarding. When this was discussed with the registered manager, they said this training would have been received however were unable to provide evidence of this.

● Other staff training records showed a number of staff had aspects of training not updated in a timely way. Including, but not limited to, infection control, fire training, moving and positioning and safeguarding.

● Issues noted in relation to training were discussed with the provider and registered manager following the site visit who agreed they would review all staff training.

● Management records did not demonstrate staff had received supervisions in accordance with the service policy. We received mixed views from the staff about the support they received from the management. This will be further reflected on within the well led domain of this report.

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

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

● People's needs were assessed before moving into The Oaks Care Home. This included their physical, social and emotional support needs, as well as some needs associated with protected equality characteristics. For example, religion, disability and relationship status.

● People and relatives told us they were involved in the development of their care plans. A relative said, "The manager and the deputy visited and asked us about his likes and dislikes. I couldn't fault the way they did that." Another relative told us, "We were all involved."

● A range of well-known tools were used to identify risks to people's health and wellbeing in line with best practice guidance. For example, the registered manager used nationally recognised tools to risk assess people's weight and to establish the level of risk to people in relation to developing pressure sores. This is further commented on within the safe domain of this report.

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

● People told us they were supported to access appropriate healthcare services when required. A person said, "I think one [GP] comes in here. We're looked after so well; we don't often need a doctor in here."

● Information relating to people's health needs and how these should be managed was not always clearly documented within people's care plans. This is further commented on within the safe domain of the report. Discussions with staff, demonstrated some staff lacked awareness of people's health conditions. Therefore, this meant we could not be assured people would be supported to access healthcare services in a timely way.

● The provider worked collaboratively with other services to meet people's needs. Staff worked in cooperation with a variety of specialist professionals including, community nurses and speech and language therapists. However, we could not be assured medical support was always requested in a timely way when injuries occurred. This is further commented on within the safe domain of this report.

● People were also supported to access community dentists, opticians and chiropodist when needed.

● People's care records included a hospital admission form which would be updated should the person be required to move between services; such as requiring a hospital stay. This helped to ensure people received consistent and coordinated care.

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

● People were supported to eat a varied and nutritious diet based on their individual preferences.

● Mealtimes were a relaxing and sociable experience for people. People and relatives were complementary about the food and told us they had enough to eat and drink. Comments from people and relatives included, "It's [food] excellent and if you don't like what they've got they get you something else" and "The meals are very good. It's good food and nutritious."

● People were provided with a choice of main meal options, however, could request alternatives if required. People were provided with drinks and snacks throughout the day.

● Where people were at risk of poor nutrition and dehydration, plans were in place to monitor their needs closely. External professionals were involved where required, to support people and advise staff.

● Individual dietary requirements and people's likes and dislikes were recorded in their care plans and staff knew how to support people effectively.

Adapting service, design, decoration to meet people's needs

● The home was clean and well maintained.

● A passenger lift connected the upper and lower floor and handrails were in place where required.

● Bedrooms and communal areas were homely and personalised to peoples interests and preferences.

● People had access to comfortable and secure outside space for them to enjoy. Communal areas were

open plan which included a spacious lounge and dining area. Additionally, a quiet lounge was also available which allowed people the choice and freedom of where to spend their time.

● Areas of the home were well sign posted, including signs outside bedrooms to help people identify their own rooms and clear signs on toilet and bathroom doors.

● People had access to specialist and adaptive equipment, including equipment to help support people to move and position themselves and to reduce the impact of falls.

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 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; 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 found multiple breaches of regulation. These failings demonstrated there was a lack of effective governance processes and systems in place to help ensure the safe running of the service. Without these systems or implementing them effectively the provider and registered manager could not be proactive in identifying issues and concerns in a timely way and acting on these. The concerns found at the inspection included but were not limited to, training, MCA, consent, safeguarding and risk management.
- Audits had failed to identify the concerns we found during the inspection. For example, the registered manager told us they completed audits of people's care plans on a monthly basis and frequently reviewed daily records. However, these checks and audits had failed to identify conflicting information within care records, the lack of risk assessments in place and the lack of detailed information in relation to people's specific care needs. This meant staff did not have detailed and up to date information about people's risks, needs or medical conditions which placed people at risk of harm.
- The registered manager and provider's systems had also failed to identify gaps in staff training, the lack of information within people's records in relation to MCA assessments and best interest decisions and ineffective management of incidents and accidents and potential safeguarding issues.
- Policies and procedures were in place to aid the running of the service. For example, there were policies on, safeguarding, training, and the MCA. However, we could not be assured these policies and procedures were adhered to, due to the issues we identified at the inspection.
- These issues were discussed with registered manager and provider who were responsive to our feedback and appeared committed to making the necessary improvements. The provider provided us with details about how these improvements would be made.

The failure to operate effective systems to assess, monitor and ensure the quality of the service was a breach of regulation 17 (Good governance) of the health and Social care Act 2008 (regulated Activities) Regulations 2014.

- We found other audits had been completed in relation to infection control, medicines, catering and environmental cleanliness. On review of these audits we noted concerns and issues had been identified and actions that were required to address the issues were recorded. However, information had not been documented when these issues had been addressed. When this was discussed with a member of the management team, they confirmed action had been taken as required and we were able to confirm this

from observation.
● We were assured the registered manager understood the requirements of duty of candour and were able to describe when and how this would be followed.

● The management team had failed to submit notifications of reportable incidents to the CQC.
● We identified the last notification submitted to CQC in relation to 'serious injury' was in November 2021. The last notification received from the service in relation to 'Other incidents' was in March 2022. At the inspection we identified nine notifiable incidents/accidents had occurred in the last three months; in relation to falls, injuries and unexplained bruising. We had not been informed of these.
● We discussed this with the registered manager who confirmed they would ensure they have a better understanding in relation to notifiable incidents and report appropriately.

The provider failed to notify the CQC of reportable incidents which was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We could not be assured people were always involved in the development of the service and their views were considered or acted on by the management team. For example, we reviewed resident meeting minutes for the last residents meeting conducted in July 2022. A comment from people at this meeting included, 'Would like to go back to having menu the day before and not being asked on the day'. However, during the site visit we observed this had not been acted on and there was no information available which demonstrated this had been considered. Another comment made at the meeting was, 'Post needs to come to residents ASAP as some aren't getting it until late', there was no evidence what action has been taken in relation to this.
● Feedback from people and staff was gained through the use of residents and staff questionnaires which were sent annually, however, on review of the latest questionnaires completed in May 2022 we could not be assured action was taken to follow up or act on feedback received. For example, for the staff questions in relation to communication with management and if staff were asked their views, four staff members rated this as required improvement or inadequate. During the inspection we had mixed views from staff in relation to the communication from the management team or if they felt listened to. A staff member told us, "The managers support staff out on the floor, especially recently and the managers are approachable and easy to talk to." Another staff member said, "The manager is very approachable, and I feel well supported by her." However other staff comments included, "I feel there is a lack of communication within the home from the managers to care staff" and "I spoke to the manager about a concern I had a couple of months ago and she told me she would do something about it, but nothing has happened."
● Within the staff feedback survey three staff rated the question, 'I know what is expected of me' as required improvement. At the time of the inspection, it was clear some staff did not have a detailed understanding of people's needs and how to manage these. For example, we asked one staff member if anyone had any issues in relation to breathing. This staff member was unable to answer this question. We asked another staff member about managing risks to people and risk assessments and they told us they were unaware of any risk assessments in place.
● We only identified one response to the resident's feedback questionnaire, with a number of their responses to questions being rated requires improvement or inadequate. This feedback indicated the person felt they were not asked for their views, there was poor communication and they were not fully involved in decisions. When we discussed the responses to the quality assurance questionnaires with the registered manager, they told us, they had, "discussed surveys where some staff and residents have said

they're not happy. We are thinking about scrapping the survey as its too difficult and we're considering doing a focus group instead." However, we were unable to identify if any action had been taken to address the issues raised.

● People were not empowered because there was a lack of understanding of the MCA process and staff did not always offer choices or inform people of what they planned or were doing where this directly affected the person. You can read more about this in the effective section of this report.

● Although we identified poor practices taking place at the home, which has been described throughout this report, on the day of the site visit we observed staff treating people in a kind and caring way. People and relatives were complimentary of the care received and spoke positively about the staff and management. All relatives spoken with told us they could raise any issues or concerns with the registered manager and were confident actions would be taken. Comments from people and relatives in relation to the running of the service included, "It's well run by [name of registered manager]. She's always on the ball. She comes to talk to you if there's anything wrong", "It is [well run]. They make sure people aren't wanting anything. It's amazing what they do" and "It's extremely well run, from the top down. The staff seem to get on, they're a cohesive team."

● Seven of the people and relatives spoken with said they would recommend the home and a relative told us about how the staff supported them and [person] to celebrate a milestone event by putting on a party and inviting family.

● Throughout the inspection it was evident people felt able to approach the staff and discuss any issues they had.

Continuous learning and improving care

● Effective systems were not in place to allow continuous learning and improving care. For example, accidents and incidents had not been robustly investigated to identify further risks or triggers or prevent recurrence and to help ensure people's safety.

● Appropriate and effective audits were not completed in a timely way to ensure improvements of care and promote safety. More details can be found within the safe domain.

● The registered manager told us they conducted regular observations of staff and the service, however, were unable to provide us with written evidence of this and could not demonstrate that actions had been taken as a result of these observations.

● The provider and registered manager did not have a formal action plan to demonstrate the plans for future development and for addressing any issues. This was discussed with the provider and registered manager who agreed to review their systems to help ensure continuous improvement of the service and to address all issues identified.

Working in partnership with others

● Whilst a visiting health professional was generally positive about their working relationship with the home, as detailed in the safe and effective section of the report the provider and registered manager had failed to contact external health professionals when required.

● Staff told us they worked in collaboration with all relevant agencies, including health and social care professionals to help ensure there was joined-up care provision.

● Staff were available to support people to attend local community events.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the CQC of reportable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to work within the principles of the Mental Capacity Act.

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 failed to ensure the safe and appropriate recruitment practices were followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate training.

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 The provider failed to ensure people were provided with safe care and treatment.

The enforcement action we took:

Warning notice

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 report concerns and follow systems and procedures to keep people safe and protect them from abuse.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and ensure the quality of the service.

The enforcement action we took:

Warning notice