Quality Homes (Midlands) Limited

Oaks Court House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**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
Oaks Court House is a residential care home and was providing personal care to 27 people aged 65 and over at the time of the inspection. The service can support up to 41 people.

Oaks Court House is located within a residential area. Accommodation is provided over three floors with passenger lift access to the first and second floors.

People's experience of using this service and what we found
The provider had not made all the improvements we identified at our previous inspection. The provider's quality assurance systems did not protect the safety of people or improve the quality of the service. Management did not fully understand the impact of risk to people and had not notified us of all incidents which had happened at the home, as required by law.

People had been placed at significant risk of harm. The provider had failed to ensure people were protected against the risk of fire. After our inspection we liaised with the fire service to address this and the provider took immediate action to reduce the risk of harm to people.

The management of risk to people's health and welfare was poor and the measures in place did not fully reduce these risks. The provider had failed to ensure adequate infection control practices were followed, which placed people at risk of cross infection. Staff struggled to meet people's needs in a timely way during busier times of the day. Accidents and incidents were not monitored to ensure the risk of reoccurrence could be reduced and lessons learnt where needed. The provider needed to improve their recruitment process in regards to how staff employment information was recorded.

The assessment of people's care needs and the delivery of their care was not fully in line with national standards, guidance and the law to ensure their needs were met effectively. Staff received the training they needed to support people, but this was not always put into practice to ensure people were supported safely.

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

Staff did not always demonstrate respect towards people. However, people and relatives commented positively about the caring nature of staff towards them.

People's care was not planned around them as an individual and did not reflect how their health and medical needs affected them. Further improvement was needed to ensure people's equality, diversity and human rights were fully represented in care plans. People had not been given the opportunity to discuss

and plan for what they wanted to happen at the end of their lives.

People's communication needs were recorded, but improvement was needed to ensure people's accessible information needs were met. The provider had a complaints process in place and concerns were addressed.

People were supported to have enough to eat and drink, access healthcare where needed and other health and social care services.

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

Rating at last inspection
The last rating for this service was requires improvement (published 16 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the management of falls and incidents and by a specific incident, following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of risk throughout the home.

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

Enforcement
We have identified breaches in relation to safe care and treatment, person-centred care, dignity and respect, gaining consent, governance and failing to notify us of incidents at this inspection.

Following our inspection we imposed a condition on the provider's registration to restrict new admissions to the home.

We are mindful of the impact of 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 closely monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Oaks Court House

Detailed findings

Background to this inspection

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

Inspection team
This inspection was completed by two inspectors and one assistant inspector.

Service and service type
Oaks Court House 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and four relatives about their experience of the care provided. We spoke with 12 members of staff including the provider, registered manager, care staff, deputy

manager and the cook.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further evidence from the registered manager and nominated individual. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with professionals from the local authority and West Midlands Fire Service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong

- People's risk assessments were generic and mostly identical to every other person in the home. Where people were at risk of falling out of bed, the control measures in place did not make sure that risk was as low as possible. The registered persons had not risk assessed the use of bed rails or of using beds which could be lowered closer to the floor. This placed people at a serious risk of harm because risk was not safely managed.
- Staff moved people using equipment they had not been assessed for, placing them at risk of harm. One person's care record stated they were moved with one piece of equipment. However, we saw staff used a different piece of equipment to move the person.
- Where people experienced anxiety and distress their behaviour could negatively impact on others. However, people had no support plans in place to guide staff on how to support them safely. Staff told us they were not confident in supporting one person when they displayed certain anxious behaviour. This placed the person and others at risk of harm.
- When people had falls, accidents or were involved in incidents staff completed accident and incident forms. However, the actions taken in response were not always sufficient to keep people safe. The action taken after one person fell was to remind them to use their call bell in their bedroom. However, this person's care records stated their diagnosis of dementia made them confused and forgetful. Therefore, this advice would not have been sufficient to reduce the risk of a reoccurrence. The registered persons could not provide any evidence of incidents being monitored and analysed to ensure actions taken had been appropriate. This placed people at risk of continued potential harm.
- People were not protected against the risk of cross infection. Throughout our visit we saw poor infection prevention and control practice. Staff wore jewellery, which could harbour bacteria and scratch people's skin. We saw poor hand hygiene practices, such as not removing gloves after supporting people and not washing their hands, despite staff having access to handwashing facilities and gloves.
- The management of laundry was not consistent with good infection control practices. We saw the laundry area was poorly organised and there was no segregation of soiled and heavily soiled laundry. One person told us their clothes came back from the laundry not smelling nice. One staff member told us, "The laundry is chaos, things are always going missing."
- The general cleanliness of equipment was not to a good standard. We found communal bathrooms were poorly maintained and posed an infection risk. Bath chair hoists were rusty, dirty and stained. We also saw moving and handling hoists and wheelchairs were dirty. People did not have their own moving and handling slings and these were shared between people in the home.
- People were not protected against the risk of fire. We found serious concerns with fire safety around the

home, including an inadequate fire risk assessment, evacuation plans and fire doors propped open. Following our inspection, we contacted the West Midlands Fire Service who conducted a fire safety inspection. Although the fire officer assured us there was no immediate risk to people, staff and visitors, the provider was issued remedial actions to complete.

● Where concerns were raised to us during our visit, we reported these to the registered manager for them to action. Following our visit, it was the nominated individual who addressed these concerns.

People were placed at risk of harm due to inadequate risk management. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our visit, we sent the provider a letter of intent. This was to inform them we may take urgent enforcement action because we had significant concerns about the management of risk. The provider and nominated individual acted promptly to address any immediate risks.

Systems and processes to safeguard people from the risk of abuse

● The provider had systems in place to protect people from the risk of abuse, but these were not consistently followed. Staff had received training and understood how to recognise abuse and how to report any concerns. However, despite the provider's systems, one allegation of abuse had not been notified to us as required to demonstrate risk had been managed safely.

● People told us they felt safe living at the home and when staff supported them.

Staffing and recruitment

● We saw at certain times of the day such as around mealtimes, staff were not always available to support people's requests in a timely way. One person told us, "The staff are kind. If I ask them for something, it takes a couple of minutes but then they come." All people, relatives and most staff we spoke with told us they thought there were enough staff to support people safely.

● The provider had told us in their PIR they based staffing numbers on a weekly assessment of people's needs. This was to ensure they had enough staff on each shift. However, the registered manager failed to provide these assessments during our visit, despite our requests.

● Staff employment references continued not to be recorded in enough detail. We saw one staff reference had no name of the referee or date recorded. This could put people at risk as the identity of referees cannot be authenticated.

Using medicines safely

● People's level of support to take their medicines safely had not been assessed. People had not had the opportunity to give their preferences on how they wanted to take their medicines or if they were able to safely administer their own medicines.

● People were supported to take their medicines when they needed them. Some people had medicines such as pain relief given to them only when they needed them. We saw staff ask people if they had any pain and required their pain relieving medicine.

● Medicines were stored securely and only staff who had been trained administered medicines to people. People's medicines records were completed by staff when they received their medicine.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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.

- The provider had failed to ensure capacity assessments and best interests meetings had taken place where staff had made decisions on behalf of people. One person's care record stated they were living with dementia and had "forgetfulness and confusion", therefore could not make decisions about their care. However, the principles of the MCA had not been followed to establish their level of capacity. This placed the person at risk of receiving care which had not been lawfully consented to.
- People's care records incorrectly stated their family would make decisions about their care. Families can only do this legally when they have a Lasting Power of Attorney (LPA).
- People's capacity to give written consent was not sought. The provider used a consent form in relation to the General Data Protection Regulation (GDPR). However, the consent forms we viewed only had a staff member's signature on them. Therefore, consent to the use of people's data had not been given or obtained in accordance with the requirements of the MCA.
- The provider had failed to ensure staff, including managers understood their responsibilities under the MCA. Not all staff, including managers could tell us how the MCA impacted on gaining people's consent. The registered manager told us they, "Had no idea when it comes to the MCA." This lack of knowledge placed people at risk of not having their rights upheld and not having decisions being made in their best interests.
- The provider and registered manager had failed to consider whether people were being deprived of their liberty. Three people had a DoLS in place at the home. The registered manager told us they had not considered if a DoLS was needed for any other person at the home. We saw people were under constant

supervision and were not be free to leave the home due to each exit being locked with a key code pad. This placed people at risk of having their liberty unlawfully deprived.

The provider failed to ensure the care and treatment of people is only provided with the consent of the relevant person. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- People received an assessment of their needs prior to being admitted to the home. The full range of people's holistic needs were not covered in the assessment and the form had not been completed fully by the assessor. The provider could not, therefore assure themselves the person's needs could be met prior to their admission to the home.
- People's assessments had not explored their diverse needs including those related to disability, gender, ethnicity, faith and sexual orientation. People's care records did not provide staff with information about how to meet these needs.

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

- At our previous inspection we raised a concern with the provider about the environment not supporting people living with dementia. Although work had started on updating the environment, this had not benefitted the people who lived there. The provider had attached signage on toilet doors but bedroom doors did not have people's names or anything to signpost the person to find them.
- People were not supported to make full use of the different spaces within the home. Different environments can have different positive effects on people living with dementia or anxiety. Despite there being other lounges around the home these were not utilised. On the ground floor there was a large, bright and airy conservatory but there was no furniture in it. People with dementia generally will be less likely to become agitated and distressed if they can have regular access to fresh air and exercise and a quiet space away from others as needed.

Staff support: induction, training, skills and experience

- Although staff had received training, they did not always put this training into practice. Managers did not confirm learning with staff to ensure they were fully competent in their roles. For example, staff received infection control training but we saw staff had not established safe practices with laundry, slings or hand hygiene.
- Some staff felt their training could be improved so they had more knowledge. One staff member told us they had not received any training on catheter care. They had been trained by other staff but wanted more knowledge to support their practice.
- People felt staff had the skills to support them and relatives felt their family members were effectively supported. Staff told us they felt supported and had opportunities to speak with managers about their job roles and get feedback on their practice.

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

- People received enough to eat and drink. One person told us, "The food is very good, and I get a choice, I don't eat cheese, they know this and always offer me something else."
- Staff were aware of people's food requirements. Where people had been assessed as requiring specialist diets such as diabetic or soft foods, this was provided.

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 saw the GP when needed and one relative told us their family member received healthcare when they needed it.
● Staff had involved other professionals in people's care such as dieticians, speech and language therapy and community health teams. Outcomes from these appointments were not always recorded to ensure staff provided consistent and appropriate 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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Staff did not always demonstrate respect towards people or treat them with dignity. People's requests to go to the toilet were sometimes ignored by staff and staff walked away as people spoke with them. One person became anxious as they were told to wait for staff to come back from supporting another person. Another person was told to urinate into the incontinence pad they wore. This was said within range of other people and the person's relative.
- One person had their lunchtime meal placed in front of them by a staff member, who then walked away. This person was blind, yet the staff member did not tell the person what the meal was or offer any support to them. It was four minutes before another staff member asked if the person needed any help. The person responded they did want help as they could not see their meal. This demonstrated a lack of respect towards the person and did not promote their dignity or independence.
- Staff, including managers, often referred to people by their bedroom numbers rather than their names when talking with us about them. People's bedroom numbers, rather than their names were used on reports and written communications. This showed a lack of respect to people as individuals.

People were not always respected. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People told us staff usually spoke with them as they supported them to make sure they were happy. One person told us even though they were not involved in their written care plan, staff chatted with them and they felt staff understood their needs.
- Despite some relatives telling us they had some concerns, they were complimentary about the care the staff gave to their family members. One relative said, "Great care. I think the staff are brilliant, they look after [person's name]." Another relative said, "The staff are wonderful with [person's name]."
- During our visit, we saw staff demonstrating some good interactions and engagement with people. Staff clearly understood people's needs and how to support them, despite this not always being recorded in their care plans.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- People were not always supported to contribute to planning and reviewing their care and support. One person, who was able to make their own decisions, told us they had not been consulted about planning their own care. We saw their care plan stated they had not been involved in this process. This placed people at risk of receiving care that did not reflect their preferences, choices or wishes.
- People who lived at the home had specific health and medical conditions, but their care plans did not contain any information about how these affected their individual lives. People's care plans were generic and did not focus on the person as an individual. People were living with dementia, Parkinson's disease, mental health issues and diabetes, yet no national or best practice guidance had been reviewed or implemented in planning their care. This placed people at risk of not receiving appropriate and person-centred care.
- At our previous inspection, the registered manager told us they were putting 'This is me' documents in place to support person-centred care. 'This is me' is used to record details about a person who can't easily share information about themselves. For example, cultural and family background, important events, people and places from their life, their preferences and routines. We saw these had been placed into people's care plans, but had not been completed.

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's care did not centre around the person as an individual or take into account their preferences, interests or abilities. During our visit people were given adult colouring books and coloured pencils. We saw very few people engaged with this and staff did not support them. One person told us they were "virtually blind". They had been given the colouring book but could not see the pictures. Despite this they said they had tried their best to colour it in. This practice did not take into account people's individual abilities, disability or sensory impairments and did not promote person-centred care.
- People were not always informed or supported to attend activities which they may be interested in participating in. During our visit, a singer performed at the home. One person was disappointed to have missed the singer as no one told them about it. Another person told us they were not interested in the activities which happened. They said they got bored because there was nothing else to do apart from watching the television.
- Peoples individual needs were not fully provided for by the home's environment. The registered manager told us they wanted the home decorated before they purchased items such as rummage boxes, memory boxes, dementia dolls and other activities which would benefit people's wellbeing.
- The registered manager told us no religious services took part at the home because no one was interested

in this. We spoke with one person who told us they had a particular faith, but were not taken to church and there were no church services at the home they could attend. This placed people at risk of receiving care which did not meet their religious or cultural needs.

End of life care and support

● The provider did not support people or their relatives to identify their end of life wishes. People did not have their wishes discussed with them or recorded, despite receiving end of life care. This placed people at risk of receiving end of life care which did not reflect their spiritual, religious, cultural or personal wishes.

People did not receive care which was person-centred. This is 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 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider told us in their provider information return (PIR), they met the AIS. They told us they did this by recording people's communication needs in their care records. Although some information was found, it was not clear from people's care plans what support they would need to understand information given to them or to communicate effectively. This placed people at risk of not understanding information to support them in making decisions and choices about their lives.

● The registered manager told us they could access information in easy read or large print if needed.

Improving care quality in response to complaints or concerns

● People and relatives told us they raised any concerns they had with staff or managers and they felt these were listened to and addressed. They had access to information on how to make a complaint and told us they discussed their concerns straight away, so they did not need to make a complaint, which they felt was more formal.

● The registered manager told us no complaints had been received since our previous inspection.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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 had failed to ensure the required improvements we identified at our previous inspection were made. Infection control audits were still not comprehensive enough to identify issues needing improvement. People still did not have support plans in place to support staff when people experienced anxiety which resulted in negative changes in their behaviour. Staff recruitment practice continued not to be managed safely.
- The provider had failed to provide us with up to date information requested about their service this included an up to date Statement of Purpose and clarity on their service user bands. This lack of response to the Commission's request demonstrated poor management and provider oversight of the location.
- The registered manager did not ensure audits in place were sufficiently detailed to identify areas needing improvement, so they were not acted on. The registered manager told us staff completed a form to confirm they had completed a cleanliness check on moving and handling equipment. However, the registered manager told us they just checked the form and did not visibly inspect the moving and handling equipment. They therefore, were not aware the equipment was not clean. Managers completed care plan audits and had incorrectly identified people had mental capacity assessments in place when they did not. This placed people's health, safety and wellbeing at risk due to poor auditing.
- We found auditing systems had failed to ensure people's care records were accurate and reflective of their current care and support. One person's personal emergency evacuation plan (PEEP) had another person's name on it. One person's care record stated they were widowed in one section, then stated they were divorced in another section. Another person's care records did not contain correct information about how they were supported to move. Inaccurate records presented risks to people's health, safety and wellbeing.
- Records relating to the management of the service were not suitably maintained to demonstrate the service was safely and effectively managed and people were kept safe. We found records related to the management of the home were disorganised and could not always be easily found when we requested them. This placed people at risk of having their health, safety and wellbeing significantly impacted by inadequate governance systems.
- The provider did not have systems in place to investigate and feedback on any incidents, accidents or near misses. This placed people at risk of harm due to the potential of incidents reoccurring.

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

outcomes for people
● Staff gave us mixed feedback about the culture at the home. Although during our visit we saw staff worked well as a team, not all staff felt this was the case. One staff member told us, "There is a culture where the day staff expect the night staff to get people up." Another staff member said, "The night staff get a lot of people up, it would be really hard if there were not already people up in the morning to get the breakfast done in time."
● On the day of our visit we saw 18 people were up, dressed and in the lounge or dining room at 8am. Not everyone we spoke with wanted to be up at that time but told us they accepted this. One person told us they wanted to be up and dressed early but rarely were. This showed a culture where people were not always put first.

The provider's poor governance did not ensure a continuous improvement in the quality and safety of care people received. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and registered manager had failed to ensure they worked to our regulatory requirements. We were aware of one person who had passed away and we had not been notified of. The registered manager told us they did not realise they needed to notify us of this person's death as it had occurred in hospital.

This is a breach of regulation 16 (Notification of death of a service user) of the Care Quality Commission (Registration) Regulations 2009.

● The provider had failed to notify us of other incidents, as required by law. We looked at the provider's safeguarding folder and saw an allegation of abuse had been made against the home six months earlier. We also found an incident report where staff had called Police during an incident at the home. Despite other people and staff being at risk, these had not been notified to us.

This is a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection, the provider and nominated individual responded quickly to the concerns we raised with them. The registered manager submitted the required notifications of the above incidents. The nominated individual quickly introduced new processes to help reduce risk. They arranged for a suitable and sufficient fire risk assessment to be completed on the home and developed an action plan to monitor improvements needed and completed.

● Despite the above, staff were positive about working at the home and told us they wanted to give people they best care they could. One staff member said, "We have a good mix of staff at present and that really helps. I like having a positive impact on a residents' day, the care is most important."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There were opportunities for relatives to give feedback about the service. One relative told us they were aware of relatives meetings but had not attended any. All relatives told us they spoke with staff when they visited and felt a part of the home.
● Staff took part in regular staff meetings and told us they had opportunities to give their feedback and opinion on the service. One staff member said, "We have regular staff meetings, we can raise concerns and talk about issues." However, some staff told us despite raising concerns nothing had changed. One staff

member told us they had discussed introducing a change to benefit people, but nothing had changed.
● Staff worked with other professionals such as, the local authority and community teams, to help support people's needs.