

Salutem LD BidCo IV Limited

Oakleigh Lodge

Inspection report

4 Oakleigh Avenue
Nottingham
Nottinghamshire
NG3 6GA

Tel: 01159602383
Website: www.salutemhealthcareltd.com

Date of inspection visit:
23 June 2022
26 June 2022
28 June 2022

Date of publication:
25 August 2022

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability, and autistic people, respect, equality, dignity, choices and independence, and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability, and autistic people, and providers must have regard to it.

About the service

Oakleigh Lodge is a residential care home which can provide personal and nursing care for up to three people. Oakleigh Lodge is a care home which does not provide nursing care. Three people were living at the care home at the time of the inspection.

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

People were not always supported by enough suitable staff to meet their individually assessed needs in a person-centred manner. This impacted some aspects of the care people received and their ability to engage in community-based activities which were meaningful to them.

People were supported by staff who had not all received specialist training in how to support people who had complex care needs.

Parts of the care home required refurbishment to enable effective cleaning and infection prevention and control.

People ate a varied diet, and mealtimes were relaxed and flexible. People's weight had not been regularly monitored and action had not always been taken when a person lost weight unexpectedly.

People were not always supported to follow and achieve their goals and aspirations. Community based activities had reduced during the COVID-19 pandemic and were still limited due to staff shortages.

Relatives were not always involved in the development of people's individual care plans and were not always informed about people's activities.

The provider had quality monitoring processes in place but had not identified all the issues which we found during the inspection. The communication of important information, from the previous registered manager to the provider, was not always effective. The provider's quality monitoring processes were not always effective, and this hampered the provider's ability to understand what was happening in the care home.

The care home layout met people's mobility support needs and people's bedrooms were generally personalised. However, some areas of the care home needed redecoration.

People were supported by staff who knew how to protect them from potential abuse or neglect and the provider had procedures in place to support that. People had access to sensory activities in the care home and in the garden area, which they enjoyed.

People's prescribed medicines were stored, administered, and recorded appropriately. People had health action plans in place and were supported to access specialist medical support services when needed.

Staff followed appropriate guidance in respect of the use of personal protective equipment and the care home had safe visiting arrangements in place.

People's communication needs were met by staff who understood how each person communicated. People's privacy and dignity was maintained. Staff were kind and compassionate when supporting people.

Right Support

People did not always receive person-centred care due to the provider not having enough staff. People had limited opportunities to engage in community-based activities which were meaningful to them. The service enabled people to access specialist health care support from the community health care teams when required. The service gave people care and support in an environment which met their sensory and physical needs. Staff communicated with people in ways that met their needs.

Right Care

Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care. People received kind and compassionate care. Staff protected and respected people's privacy and dignity; and understood how to protect people from poor care and abuse.

Right culture

Staffing levels affected how the service could meet people's needs and wishes. Not all staff had received the specialist training necessary to understand best practice; in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. However, staff knew people well and placed people's wishes, needs and rights at the heart of everything they did.

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 20 August 2019).

Why we inspected

We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. The inspection was also prompted, in part, by our receipt of concerns relating to staffing levels and personalised care. This inspection examined those risks.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches of regulations 9, 15, 17 and 18 in relation to staffing levels, person centred care, hygiene, and governance processes, at this inspection. We have issued the provider with a Warning Notice.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always 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?

Good ●

The service was caring

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement ●

The service was always well-led.

Details are in our well-led findings below.

Oakleigh Lodge

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 prevention and control 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

One Inspector, and a member of the CQC medicines team, carried out the inspection.

Service and service type

Oakleigh Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Oakleigh Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission as they had recently left their position. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection, day to day management support was provided by the provider's Divisional Support Manager. Additional management support was provided by the deputy manager.

Notice of inspection

The inspection site visits on 23 June 2022 and 27 June 2022 were both unannounced. A member of the CQC medicines team also carried out an announced inspection visit on 28 June 2022.

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 also used the information the provider sent us in the provider information return. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We communicated with three people who used the service. For people who were unable to communicate verbally, we spent time observing their body language during their interactions with care staff to help us understand the experience of people who could not talk with us. We used the Quality of Life Tool which is designed to support the corroboration of all sources of evidence gathered during inspection.

We spoke with 10 members of staff including care staff, agency care staff and the Divisional Support Manager.

We reviewed a range of records. This included three people's care records and three medication records. We looked at three staff files in relation to recruitment and staff supervision.

After the inspection

We continued to seek clarification from the provider to validate evidence found. A variety of records relating to the management of the service, including policies and procedures, were reviewed. We looked at training data and quality assurance records.

We received feedback about the service from three external professionals who had recent and ongoing involvement with the service. We received feedback from three relatives of the people who live at the care home. We also received feedback, by phone or email, from four staff.



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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- The provider did not always have enough staff on shift to meet people's assessed care needs. The provider told us they assessed each person required one-to-one support for 13 hours each during the daytime. They told us they had consequently increased their staffing levels to meet people's identified one-to-one care needs. However, there were regularly periods during the mornings and early evenings, and occasionally at other times, when only two staff supported the three people. This did not meet people's assessed care needs.
- A relative told us, "I am worried about the staffing levels. They tell us they always have three staff on, but, when we visit, we often find only two. We have repeatedly raised the issue that only having two staff is unsafe and is not practical when it's two-to-one for personal care."
- People's ability to take part in individual community activities was sometimes limited. For example, in the community, each person sometimes required two staff to support them. The provider's staffing levels therefore often limited people's ability to take part in those individual activities.
- People's ability to use the provider's specially adapted minibus was affected by staffing issues. The provider had a limited number of staff who were qualified to drive the minibus, and this reduced opportunities for people to travel to community activities.
- The provider required care staff to carry out the cooking and cleaning tasks in addition to supporting people. This further reduced the availability of staff to provide one-to-one care support to people at certain times of the day.
- Staff had not received specialist training, at a level appropriate to their role, to support people who have a learning disability and autistic people, or people who have complex physical disabilities. We raised this with the manager who told us the training would be arranged for the staff.
- There was a reliance on agency staff to fill gaps in the rota as the provider attempted to recruit additional permanent staff. The provider aimed to use the same agency staff where possible to improve consistency of support for people. However, the provider did not have basic employment details, or training records, available for all the regular agency care staff they used. The lack of information meant the provider could not be certain all the regularly used agency staff were safely recruited or if they had the skills, training, and experience needed to meet people's care needs.

We found no evidence people had been harmed, however, the provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of the people receiving care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection; Learning lessons when things go wrong

- People were not always protected from the spread of infection by the hygiene arrangements in the care home. For example, the laundry room of the care home was unclean, cluttered, and in poor condition. This increased the potential for health infections to spread due to the inability to effectively clean that area.
- The communal toilet/shower room was cluttered with people's personal toiletries and presented a risk of cross contamination. This was identified previously during an audit carried out by an external infection prevention and control clinician, but the provider had taken no action. The inspector raised this with the manager who immediately arranged for people's personal toiletries to be safely stored in their individual bedrooms.

The provider failed to ensure all areas of the premises were kept clean and hygienic. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There had been few incidents or accidents at the care home. But when they did occur, they were reported appropriately and any lessons learned identified to reduce the likelihood of recurrence.
- Potential health infections were not always risk assessed by the provider. The provider was previously advised, by an external infection prevention and control clinician, about the need to risk assess specific infectious diseases (other than COVID-19) and for records to be kept of whether staff had been offered the vaccine. However, the provider had decided not to do this. This was not in line with current relevant safety guidance.
- The service prevented visitors from catching and spreading infections.
- The service followed shielding and social distancing rules.
- Staff used personal protective equipment (PPE) effectively and safely.
- The service tested for infection in people using the service and staff.
- The service's infection prevention and control policy was up to date.
- The service supported visits for people living in the home in line with current guidance.
- All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse

- People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse.
- Staff had received training on how to recognise and report abuse and they knew how to apply it.

Assessing risk, safety monitoring and management

- The provider had risk assessment processes in place, to determine how to provide people with safe care.
- Staff assessed people's sensory needs and did their best to meet them. There was a sensory room which we observed people enjoyed spending time in. The garden had a covered patio area so people could spend time outside if they wished.
- The service helped keep people safe through formal and informal sharing of information about risks. For example, the provider had recently notified the local authority that they believed the current level of commissioned support hours did not meet a person's individual care needs.
- The provider carried out routine environmental checks and ensured all equipment was maintained and serviced appropriately.

Using medicines safely

- People were supported by staff who followed systems and processes to administer, record, and store medicines safely.
- Staff followed effective processes to provide the support people needed to take their medicines safely. For example, staff took the time to tell each person which prescribed medicine they were being given. Although the person we observed may not have fully understood what they were being told, we saw the calm and respectful communication from the staff relaxed the person.

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

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

- It was not clear support always reflected people's preferences. For example, the manager told us people preferred to change into their pyjamas in the early evening. However, a staff member told us the day staff sometimes supported people into their pyjamas in the early evening to make things easier for staff on the next shift, because they knew there were only two staff on shift from 8.30pm. A relative told us, "When I asked why [Person] was in their pyjamas so early, the staff told me that it is in their care plan that they put them on in the early evening. But I have never seen that care plan."
- People had care and support plans in place. However, they were not regularly reviewed and there was no evidence of the involvement of people or those important to them. A relative told us, "I have asked for a meeting to go through [Person's] care plan, but nothing came from it."
- When asked by the inspector, the manager told us they intended to involve relatives in the review of people's care plans when the care plan information had been transposed onto the provider's new electronic care record system. At the time of the inspection though, the care plans were still paper based.
- Care staff told us they knew how to support people, but there was no evidence in people's care plan folders that staff had read people's individual support plans and risk assessments.
- Agency care staff were not always aware of people's health support needs. The provider aimed to use regular agency staff members to fill gaps in the rota. However, some regular agency workers told us they did not know who had a particular health condition which might require emergency medicine to be given. This placed people at increased risk that they might not receive the emergency support they needed in a timely manner.

The provider failed to carry out, collaboratively with the relevant person, an assessment of the needs and preferences for the care and treatment of the service users. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People were supported by staff who had received relevant basic care training. However, a staff member told us, "We struggle doing the online training because we usually have to do it while we are on shift, and it's hard doing it at work because we just don't have the time like we used to."
- Staff told us they had received the basic training required to support people, and we saw they implemented their training appropriately.
- Training records were not complete and did not always evidence which specialist training staff received to support people's complex needs. This meant the provider could not effectively monitor staff specialist

training needs.

- Most staff told us they felt supported by their managers and described them as knowledgeable. A staff member told us, "I highly enjoy working with my supportive, talented, colleagues and find I receive lots of support from management."

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

- People's food support plans contained conflicting information. For example, a person's food support plan stated their food should be cut up into '50 pence coin' sized pieces. However, their Speech and Language Therapy guidance notes stated their food should be cut up into '5 pence coin' sized pieces in order to reduce the risks of harm from choking. Conflicting guidance for staff increased the risk that people might be harmed from being given food in a texture which was not safe for them. The inspector raised this with the manager who told us they would obtain guidance from the Speech and Language Therapy Team and update the care plan accordingly.
- People's weight was not consistently monitored. Although still at a healthy weight, two people had unexpectedly lost weight over the course of previous months and no action had been taken. This was raised with the manager who told us they would immediately contact a dietician for specialist advice on how to support people to maintain a healthy weight.
- People received support to eat and drink and relied on staff to offer options for them to choose from. A relative told us, "[Person] can't tell me, because they have no verbal communication, but I have been there while [Person] is having a meal and they seem to like it. They eat as well as they would anywhere."
- People received support to eat and drink in a way that met their personal preferences. Mealtimes were informal and flexible to meet people's needs.
- People were supported to have meals in line with their cultural preferences and beliefs. For example, the provider ensured appropriate food options were available for a person who had specific cultural requirements.

Supporting people to live healthier lives, access healthcare services and support

- People had health action plans/health passports which were used by health and social care professionals to support them in the way they needed.
- People were supported to attend health checks and primary care services, such as GPs, and specialist community health services, when necessary.
- Multidisciplinary team professionals were involved in guiding care staff about the support people needed. There had been delays in obtaining specialist support and equipment for one person, due to limitations created by the COVID-19 pandemic. The manager told us they were following this up to ensure the necessary equipment was obtained and specialist training provided to the care staff by the appropriate external healthcare professional.

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

- People's bedrooms were somewhat personalised, but some contained areas which required further re-decoration. For example, the provider had installed new ceiling track hoists in some rooms, but the marks left by the old hoist tracks had not been covered up.
- Some areas of the care home required refurbishment and redecoration. A relative told us, "When the new company took over there was talk about doing all sorts with the structure of the building, but none of that has actually happened. There has just been a bit of decorating carried out by the staff at Oakleigh."
- People enjoyed using the sensory room, and there were also large safe mats which could be put down in the lounge area to enable people to spend time relaxing and stretching if they wished to.
- The provider had increased the paved area in the garden to make it more accessible for people to use. They had also provided a covered area so people could spend time doing activities outside and be

protected from the elements.

- People were supported to move around easily because the care home was level access. The design, layout and furnishings of the care home supported people's individual mobility needs.
- The provider had identified parts of the care home were cluttered. They had already started to dispose of excess items in order to free up storage space for things people still required.

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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff empowered people to make their own decisions. For example, about activities within the care home, and their food and drinks.
- Staff knew about people's capacity to make decisions through verbal or non-verbal means and this was documented in their care plan. For people who were assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions.

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 remained the same. This meant people were supported and treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were patient and used appropriate styles of interaction with people. A relative told us, "I have never had a bad word to say about the staff at Oakleigh. The staff are very good."
- People received kind and compassionate care from staff who used positive, respectful language which people responded well to. Staff created a warm and friendly atmosphere.
- A person told us they liked living at the care home and said the staff are "nice" to them.
- Staff appeared calm, focussed, and attentive to people's emotions and support needs, including the need for sensory stimulation within the care home.

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

- People were listened to and valued by staff. We observed staff using a patient and respectful approach to offering people choices. People were given time to listen, process information and respond to staff. Staff respected people's choices and, wherever possible, accommodated their wishes.
- Staff took the time to understand people's individual communication styles and develop a rapport with them. For example, one person expressed their choices by using their eyes to 'point' at the option they preferred. Other people used verbal communication or body language and the staff adapted their communication style to meet the needs of the person they were communicating with.
- Staff supported people to maintain links with those important to them. A relative told us, "The staff are doing very well. They do more than what they are expected to do. I know they aren't family, but they treat it as not just a job. It seems almost like family."

Respecting and promoting people's privacy, dignity and independence

- People's dignity and privacy was protected when they were being supported with personal care tasks. For example, staff ensured personal care tasks were carried out in people's own rooms, with the door closed.
- Care records were securely stored, and computers were password protected.

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 achieve their individual goals and aspirations. For example, a person's care plan indicated they enjoyed swimming; an activity which would be beneficial for their physical wellbeing. A staff member told us the person used to be supported to go swimming regularly but that had ended, partly because of the COVID-19 pandemic, but also because the staffing numbers on each shift made it difficult to support them to that activity.
- Relatives confirmed activities had decreased over recent years. One relative told us, "[Person] used to be out most days doing lots of things. That died off a bit during COVID-19, understandably. But hopefully they will start to do more again."
- Another relative told us, "[Person] just loves being outside watching things happening. They love that. We wanted them to be somewhere where they could get out and watch things each day. But they still aren't getting out much these days."
- A staff member told us, "I don't think the residents get enough time in the community like they used to. Most of the time they just sit around in the lounge. At one time they used to go on day trips at least two or three times a week and have access to the parks and shopping on a regular basis. They had a very good social life and used to go to a leisure group as well. That doesn't happen much now because of the shortage of staff and using a lot of agency workers."
- The provider's records showed there had been a limited range of external community-based activities provided to people. The most common activity being a walk to the local shop and back. This meant people were not always supported to engage in activities which were important to them.

The provider failed to ensure people received care and treatment with a view to achieving service user's individual preferences and ensuring their needs are met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Some relatives were not always kept informed about activities people engaged in. For example, a relative told us, "They never tell me what activities [Person] has been doing. When [Person] first moved in, the manager said they would send me a weekly email so I knew what they had been doing. But that never happened."
- Relatives told us the staff had worked hard to maintain contact with them during the COVID-19 pandemic and that visiting arrangements had been put into place as soon as the Government guidance allowed them.

- People who were living away from their local area were able to stay in regular contact with friends and family via telephone/video calls if they wished.
- Staff supported people to participate in activities within the care home, which people engaged in and enjoyed. This included sensory activities, watching films, listening to music or taking part in leisure activities in the garden.
- Staff helped people to express their choices about the activities they wished to engage in within the care home.

Improving care quality in response to complaints or concerns

- Relatives gave us mixed feedback on the provider's approach to concerns and complaints. One relative told us they had complained several times to the provider and had not had the issues resolved properly. They told us, "I just feel I am being fobbed off. I don't know what else I can do. They just aren't listening."
- Another relative told us, "I haven't had any problems with the care home, but if I did then I have the manager's and deputy manager's number and I know they would sort the problem out for me."
- The provider told us the complaints they received were generally about the staffing levels, which was also impacting on the activities that could be provided for people. They told us they had tried to explain the difficulties they were having in filling staff vacancies and negotiating additional funding from the relevant local authority commissioner.
- The provider had an appropriate complaints policy and procedure which was available for people to access. The provider logged formal complaints along with details of the actions they had taken to resolve them.

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.

- There were visual cues, including objects, photographs and use of gestures which staff used to help people make choices.
- People had individual communication guidelines which detailed effective and preferred methods of communication, including the approach to use for different situations.
- Staff had a good awareness of people's individual communication need. They knew how to facilitate communication and when people were trying to tell them something.

End of life care and support

- Discussions on end of life care had taken place where the person and family wanted their wishes to be known. Where this had not been discussed this was recorded in the person's support plan.
- The provider had a suitable end of life policy and procedure in place to guide staff. However, there was nobody receiving end of life care when we inspected.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider had a quality monitoring system in place. However, we found some issues during the inspection which had not been identified by the provider's quality audits. For example, hygiene and cleanliness concerns of parts of the care home, care plans, and staff training.
- The provider's internal communication processes were not always effective. For example, an external quality audit, and important information about a person's healthcare, had been shared with a previous registered manager by relevant healthcare professionals. But the provider was not aware of that and improvement actions were consequently delayed.
- The provider had not taken action to ensure staff received the specialist training they needed to be able to support people who had complex care needs. This meant the provider was not appropriately monitoring the training requirements of staff employed at the care home.

The provider failed to have effective systems or processes in place to assess, monitor and improve the quality and safety of the services provided, including the quality of the experience of service users in receiving those services. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had the skills, knowledge and experience to perform their role and a clear understanding of people's needs in the service.
- The provider had refurbished parts of the care home, to improve people's living environment, but further work was required.
- The provider reviewed incident reports to identify areas for improvement to prevent recurrence. For example, when staff made a minor error when administering prescribed medicines to people. The error was discussed with the staff member and additional training provided if required.

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

- The manager spent time with staff discussing behaviours and values. The manager and deputy manager occasionally worked directly with people and led by example.
- Staff told us they felt supported and valued by their managers. Some staff told us they felt able to raise concerns with managers without fear of what might happen as a result.

- The manager promoted equality and diversity in all aspects of the running of the service.
- The manager demonstrated they valued reflection, learning and improvement, and they were receptive to challenge and welcomed fresh perspectives.

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 shared information with people and their relatives when things had gone wrong. The manager ensured people's relatives were notified about any issues and incidents.
- The provider made all necessary statutory notifications to the CQC. This is a legal requirement placed on care providers. Receiving notifications enables the CQC to monitor regulated services and identify where there may be potential risks which need to be addressed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People's relatives were not always involved in shaping people's care plans. Most relatives we spoke with had not seen people's care plans, which were created by the management team. The provider told us they intended to invite relatives to be involved in care plan reviews once the information had been set up in their new electronic care record system.
- Staff received appropriate equality and diversity training in how to ensure people's equality characteristics were considered when providing care to them.
- Details of people's individual equality and diversity characteristics were recorded in their care notes and considered when care was being planned.

Working in partnership with others

- External health care professionals told us the service worked in partnership with them to help maintain people's well-being. For example, an external health care professional told us, "The support team are highly motivated, responsive and have always communicated and engaged very well with our service."
- Relatives told us the care staff kept in touch with them about any significant issues relating to people's health issues, and the provider's records evidenced that.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to carry out, collaboratively with the relevant person, an assessment of the needs and preferences for the care and treatment of the service users.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure all areas of the premises were kept clean and hygienic.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed to have effective systems or processes in place to assess, monitor and improve the quality and safety of the services provided, including the quality of the experience of service users in receiving those services.</p>

The enforcement action we took:

We issued the provider with a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of the people receiving care.</p>

The enforcement action we took:

We issued the provider with a Warning Notice