Russell Court Care Home Ltd

Russell Court

Inspection report

Overfield Road
Dudley
DY1 2NY

Tel: 01384985040

Date of inspection visit:
12 November 2020
18 November 2020

Date of publication:
20 April 2021

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
Russell Court is a residential care home providing personal and nursing care up to 42 people. As part of the local area's response to the COVID-19 pandemic, the service had agreed with a local hospital to reserve 21 of the care home beds for people recently discharged from hospital. People went into isolation in their rooms on arrival to the home, due to risks associated with COVID-19. Some people were recovering from COVID-19 and following a hospital stay.

There was a quick turnaround of people staying at the home, with some people staying for a short period of a number of days or weeks. On the first day of our inspection, the service was supporting 23 people and on the second day of our inspection six days later, the service was supporting 30 people. Two people lived at the home on a longer-term basis.

People were accommodated in one building that had been adapted to provide designated areas for people with and without COVID-19, to help reduce the spread of infection. People who joined the service with a positive COVID-19 test were cared for in a separate wing which was designated for people with COVID-19 to reside in. There were additional wings and areas of the home designated to care for people who did not have COVID-19.

People's experience of using this service and what we found
We identified a breach in relation to safe care and treatment because people's risks were poorly assessed and we found widespread, significant concerns as to how the service managed people's medicines and the risks associated with COVID-19. Incidents were not learned from to help improve the safety of the service. Though we saw staff were aware of safeguarding concerns being referred to the local authority, not all staff had received safeguarding training and not all staff understood their responsibilities in protecting people from abuse. Feedback indicated there were enough staff to meet people's needs and on the whole, recruitment processes were safe. We asked the provider to immediately address shortfalls where they posed risk of harm to people. Although the provider gave us assurances they would do so after the first day of our inspection, our second site visit six days later found continued shortfalls in this area and additional ways that people and staff were being exposed to risk of significant harm. The provider could not demonstrate that people's risks were consistently well managed. However, we saw some examples of how people's risks and needs were responded to appropriately.

We identified a second breach of the regulations due to the provider's poor systems and oversight of the quality and safety of the service. Despite the provider's role in the local response to the pandemic and supporting people with COVID-19, they had not ensured their service was fit for purpose to safely meet people's needs and manage infection risks. We needed to ask for immediate concerns around infection control to be addressed. We saw additional widespread concerns in relation to care planning to meet people's individual needs and wishes. At the time of the inspection, relatives described the service's communication as poor and we found there were no systems in use to effectively gather feedback to

improve the quality of the service or to help inform person-centred care. The provider understood their regulatory requirements. The provider acknowledged our concerns and after our inspection, decided to suspend further admissions to the home whilst they addressed concerns with input and support from the local authority.
Staff told us they felt supported and welcomed recent improvements to the home. However, the provider's training plans had not been maintained to ensure all staff received the training and supervision required for their roles. Poor quality care records, combined with staff training gaps, did not give us assurance that people's needs could be effectively met at all times. Care staff and nurses described good communication with one another, for example to escalate if someone became unwell, and staff did show understanding of action they should take if people's needs changed.

People were supported to have maximum choice and control of their lives and staff were supporting people in the least restrictive way possible and in their best interests. However, the policies and systems in the service did not support best practice and the new manager had identified further improvements were required in this area.

Feedback we received indicated people were offered enough to eat and drink, though systems did not ensure people's feedback and preferences were always captured. We saw concerns as to how people's dietary needs were responded to and prompted for improvements to be made to how this was monitored. Relatives and staff spoke positively about the premises.

We saw caring and warm staff interactions towards people, which was reflected in compliments the service received. Improvements were required to ensure people's dignity and respect were always promoted, though staff gave us examples of how they tried to achieve this. Care planning processes did not always ensure people were well treated or to involve people in discussions about their care as far as possible. This meant people's needs around equality and diversity, and gaining more independence, were not always explored as far as possible.

People were generally satisfied with the service provided yet their focus was on recovering and returning home. We found not enough was done to ensure people's individual needs were understood and met as far as possible, and we found multiple examples of inconsistencies and insufficient guidance within people's care records. This included key risks and decisions and put people at risk of poor care and experiences, and limited information within people's end of life care plans. This was recognised by the provider and we were told immediate improvements were underway.

An activity coordinator had been recruited to help improve access to activities, due in part to the majority of people self-isolating at the time of the inspection. We were told most people had their own pastimes and ways of keeping in touch with loved ones, however the service had not ensured this was a consistent experience for all.

Complaints processes were not used effectively to help improve the quality of the service. Feedback we received indicated people and relatives were not all familiar with the complaints process.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
This service was registered with us on 23 March 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns we received from the local authority about how

people's needs were being met. A decision was made for us to inspect and examine 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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the full report for more information. You can see what action we have asked the provider to take at the end of this full report. We raised our concerns with the provider through our inspection and enforcement processes and received assurance that the concerns were acknowledged, and improvements were underway.

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 in relation to safe care and treatment and good governance. 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.

Follow up
We will continue to monitor information we receive about the service moving forwards until we return to visit as per our re-inspection programme. This includes working with the local authority to monitor progress. If we receive any concerning information we may inspect sooner.
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**

Russell Court

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
The inspection was carried out by two inspectors and a specialist advisor.

Service and service type
Russell Court 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, however they had recently left. A new manager and clinical lead had joined shortly before our inspection. The new manager had not yet registered. The registered manager 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. We called the provider when we arrived at the premises to check key information related to COVID-19 to help reduce associated risks and to help keep everybody safe.

What we did before inspection
We reviewed information we had received about the service since its registration in March 2020. This included notifications from the provider which they are required to send us, for example about incidents and changes at the service. We also attended a meeting with the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report. We referred to the information available within the provider's recent registration report, held by CQC in relation to the provider's registration in March 2020. We used all of this information to plan our inspection.

Before our inspection site visit, we requested evidence about the provider's systems to monitor the quality and safety of the service, including complaints and compliments, training records and about incidents at the service. We also spoke with the nominated individual, the new clinical lead, a night carer, a care assistant, the head chef, the deputy manager and a domestic staff member over the phone. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with three relatives and two health professionals about their experience of the care provided.

During the inspection
We spoke with two people who used the service and a visiting health professional about their experience of the care provided. We met and spoke with the new manager, the new clinical lead and the nominated individual. We spoke with a senior care staff member, an agency nurse, four care assistants and four domestic/housekeeping staff.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment, fire safety, incidents and training. 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 and we spoke with another health professional involved with the service. We also continued liaising with the local authority in relation to the concerns we had identified.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- People's identified risks were not consistently assessed and managed, for example how to safely manage people's catheter care and falls risks.
- One person was at risk of falls and had joined the home in August 2020. We saw this person's falls risk had not been assessed for ways to help keep them safe. This minimal action was still not taken including when the person suffered a fall at the home in September 2020. The incident log referring to their fall had also still not been reviewed to help identify how to prevent further harm to the person.
- Risks posed by the service were not effectively managed. For example, people's personal emergency evacuation plans were incomplete to help inform the support they would need in the event of a fire. We needed to prompt the provider to revisit fire safety procedures with staff to ensure all staff had an informed, consistent understanding of how to respond in the event of a fire.
- We identified widespread concerns about how people's medicines were managed which put people at risk of receiving unsafe care. Minimal basic details such as support plans to inform safe medicine support were not in place for people. These concerns were exacerbated by the use of agency nurses who would be less familiar with the identity and needs of people using the service.
- We saw 13 people did not have necessary protocols in place to inform the safe use of their PRN ('when required') medicines, and reasons for people's PRN use were not adequately monitored. This did not ensure people received medicines safely and as prescribed and to take further action when needed. After our inspection, the manager introduced a new audit to rectify this.
- Medicine records also lacked key guidance about how to safely support people with prescribed patches and how to follow special administration instructions to maintain the efficacy of medicines.
- We identified numerous shortfalls in infection prevention and control. Our findings did not assure us the provider was making sure COVID-19 outbreaks were effectively managed.
- Visiting to the service was limited at the time of the inspection due to a national lockdown, though systems still needed to be improved to prevent the spread of infection.
- Staff had not been deployed into cohorts to help reduce the risk and spread of infection and had not been risk assessed in relation to their own exposure to COVID-19. One staff member told us, "We work on different wings each day, it's not right. Yesterday I was on a COVID-19 wing, today I'm on another unit." We raised our immediate concerns with the provider.
- We found widespread concerns about how staff used PPE. Staff had not all been trained and supported to understand how to use PPE safely which put both people and staff at risk. We saw concerns whereby some staff either did not wear or did not always correctly wear face masks in and around COVID-19 designated areas of the home. Conversations with some staff showed they used their best judgement about how to use

PPE which showed they did not have an informed, consistently safe approach to protect themselves and others from the spread of infection.
● We found concerns about the layout and hygiene practices of the premises and we were not assured the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● On the first day of our inspection, we raised immediate concerns with the provider in relation to infection prevention and control and the poor management of COVID-19 related risks.
● We were told improvements had been made, yet we found continued and further significant concerns on the second day of our inspection, six days later. This demonstrated poor learning from the provider and their ongoing failure to identify and address significant concerns continued to place people and staff at risk of harm.
● Records we saw detailed immediate, reactive steps taken in response to incidents, for example to check a person was safe after a fall. Although incidents were responded to at the time, incidents were not reviewed individually or overall to help identify and reduce future risks as far as possible, for example to review a number of falls at the home and potential causes. There were no processes in place to promote such learning and improvement at the time of the inspection.

Due to widespread and significant shortfalls in the safety of the service, people were placed at ongoing risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Please see the action we have told the provider to take at the end of this report.

We shared the above concerns with the local authority. We also signposted the provider to safe infection prevention and control resources. Regarding medicine concerns and risk management, the provider gave us immediate assurances of some actions taken and told us they would promptly carry out a medicines audit.

● Not all staff had received fire safety training, though some planned training was postponed due to extenuating circumstances. Staff told us they completed regular fire drills and most staff gave consistent responses regarding the location of the fire assembly point.
● Records indicated timely health and safety plans were carried out. We saw the home was kept clean and odour-free. One person told us their room was kept clean and tidy.

Systems and processes to safeguard people from the risk of abuse
● Not all staff had received safeguarding training and there were inconsistencies in staff knowledge of safeguarding processes. Some staff were aware of the types of abuse people could experience and how to report this to protect people, yet other staff lacked this knowledge.
● We saw safeguarding concerns were raised with the local authority to help protect people.

Staffing and recruitment
● Most staff told us there were enough staff to safely meet people's needs. A relative told us they felt there were enough staff and commented, "When we visited, there were always nurses around and close by. They also popped their heads around the door to make sure everything was okay."
● The exception to this feedback was housekeeping staff, though recruitment was underway at the time of the inspection. After the inspection, the provider confirmed housekeeping staff had been employed and rota planning had been improved to reduce pressure on housekeeping staff.
● Agency staff were used though new nurses had been recruited to the service in recent months and there were three permanent nurses.
● All staff told us they completed safe recruitment checks before joining, which included reference checks

and DBS checks. Our sample of records confirmed this, aside from a staff member who the provider had not completed a DBS check for although records showed the staff member had joined in August 2020.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Staff support: induction, training, skills and experience

- We found multiple examples where people's identified needs were not adequately assessed and records about their care needs did not provide enough guidance to inform consistent, effective support. This included risk assessments for a range of people's needs including falls risks, catheter care and diabetes care.

- This, combined with training gaps presented risks that people's needs could not be effectively met, or changing needs quickly identified, with only a small group of staff having received training in these areas.
- Staff told us they completed an induction and training when they first joined the home along with refresher e-learning training. However training plans had not been maintained for new and incoming staff over recent months and there were several gaps in the provider's training, including in relation to Food Safety, dementia care, First Aid, safeguarding and infection control.
- Staff told us they felt supported overall and staff received supervision three-monthly, however this meant newer staff had not received any supervision since joining the service.
- After our inspection, the provider told us that support and guidance for staff had increased, which included face-to-face training and effective monitoring tools provided by the local authority to support improvements. The provider also told us they had streamlined and implemented new, clearer risk assessments in response to the concerns we had brought to their attention.

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

- Our inspection found some people's dietary needs were inaccurately recorded and health professional recommendations were not always followed. For example, one person was prepared foods at a softer consistency than required which did not promote enjoyable mealtimes. This was not picked up despite subsequent concerns raised about their weight loss.
- Discussions with people and staff indicated people were given enough to eat and drink. One staff member told us, "We keep going round, topping everything up and make sure people are eating and drinking well, and if not we tell the nurse in charge." We received some negative feedback however about the quality and choice of the food provided. We also found systems did not effectively capture people's preferences and feedback in relation to food and drink to help drive improvements.
- Systems to monitor people's fluid intake were unclear and people's records we saw contained gaps and incomplete guidance. This made it difficult for staff to understand some people's support needs and to accurately record how they had supported people to have enough to drink. This had already been identified by the manager and was being improved at the time of the inspection.

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

● Although health professionals were involved in people's care, with some regularly visiting people at the service, records were not accurately maintained to help inform ongoing effective support for people and to reflect health professionals' recommendations. This failed to ensure health professional recommendations would always be understood and followed. The manager told us they would be addressing this with staff and health professionals moving forwards.

● Conversations with care staff and nurses indicated they worked well together to respond if people were unwell and needed further healthcare support. Records we sampled showed examples of changes in people's needs being identified and responded to, though this was not consistent.

● There were limited proactive means of promoting healthier lives and wellbeing for people in place at the time of the inspection beyond the basic care provided. One person's records showed an assessment in September 2020 indicated they have depression. We could not see, and the provider could not tell us what had been done to help support this person.

● Health professionals described recent improved communication. A health professional told us, "Initially things were a bit haphazard, and there was not continuation of care… you got the impression staff didn't really know the residents as different people were caring for them. The last few weeks, it has improved… things are more organised."

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

● We could not fully determine how well the service had been adapted to meet people's needs as the majority of people were isolating in their own rooms at the time of the inspection. We did however identify concerns that the service had not responded enough to COVID-19 related risks to ensure there were adequate infection control facilities and arrangements including in communal and staff areas.

● Feedback from relatives and staff indicated the premises had considerably improved since the provider had opened the home. One staff member told us, "They've really put a lot of work in[to the home]."

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.

● Staff told us they promoted people's choices but did not always demonstrate understanding of the Mental Capacity Act (2005) and the provider's training matrix showed only four staff had received training for this. Regarding DoLS, a staff member told us, "I'm not sure about that as the nurses deal with all that", however this was an area all staff should be familiar with to ensure people received appropriate support at all times.

● We were told that on the whole most people had capacity to make their own decisions. We were not given evidence or records to demonstrate people's choices and wishes were proactively sought to help inform their care. The nominated individual acknowledged this aspect of people's care needed more attention to ensure the service always worked within the principles of the MCA.

● No DoLS applications had been made for people using the service at the time of the inspection and the information we received indicated this level of support was not required.

● The manager told us people had been consulted on the use of CCTV around the home and provided one

person's care records as evidence of this. The manager showed us there was signage around the home to alert visitors to the use of CCTV.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

● Our discussions with leadership and relatives found communication and support was often poor and reactive including when people joined the service. This did not ensure people were well cared for at all times. For example, one relative told us, "He'd already been in a while when in one call I said, 'I don't suppose he can have his own things?' Staff said, 'Yes he can, it'll be good because he hasn't got his own clothes.' It would have been better if they told me that at the start – this might have helped him settle better." After our inspection, the manager described how they had improved communication with the hospital and relatives to help ensure people could access items important to them, and that loved ones were informed of people's care journey from hospital to the home. Systems had not previously ensured this proactively happened.

● Care planning processes had not adequately explored people's social and cultural needs to ensure equality and diversity needs could always be identified and respected. A staff member told us, "At the moment I don't know of anyone who has any preferences… Sometimes on admission, this information is gathered, not always… it depends on how and when residents are admitted." We could not be assured therefore that people's individual needs were always known and considered.

● The chef told us they had prepared meals in line with people's religious requirements.

● People's limited time at the service meant people and staff could not always get chance to get to know each other well, however staff told us there was time to chat with people and we overheard and saw warm, caring interactions towards people from staff. A relative told us a person's birthday had been kindly marked and celebrated. One person told us, "I can't fault the staff, they're really good."

● The nominated individual and manager praised the caring approach of staff. Compliments the service had received from people and relatives echoed this and demonstrated people and staff had built up good relationships. One relative told us, "Whenever we have seen him he has been laughing with staff."

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

● People were not routinely involved in discussions about their care or processes to help gather their views and preferences. Records we saw in relation to people's individual preferences and personal histories were poorly completed.

● Staff told us people were able to ask for what they wanted. People spoke positively about staff in general but told us there were not often familiar faces they could get to know.

Respecting and promoting people's privacy, dignity and independence

● One person was recovering from a fracture and described steps they were taking to promote their

independence and improve their mobility. This, and additional areas of support to balance the person's safety and independence were not captured in their care planning. We asked the provider to talk through this person's needs with them.

● Staff told us people's laundry items were not labelled to help make sure people had access to their own clothes and to prevent their items being misplaced. A relative told us about a person's personal items that had been lost. The manager told us this was being addressed.

● Staff gave us examples of how they promoted people's privacy and dignity and we saw this in practice. For example we saw staff knocked on people's doors and identified themselves on entering people's rooms. A staff member told us, "You've got to show respect… like how you would like your own family to be cared for, your own mum and dad."

● After the inspection, the manager told us having completed self-isolation to prevent the spread of infection, people were now being encouraged to spend time outside of their rooms and with other people. This was important to help improve people's mobility, independence and wellbeing.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

● Although people's stays could be short-term, not enough was done to ensure people's individual needs were understood and met as far as possible. Care planning processes did not take account of the full range of people's needs including their individual preferences and experiences of the service, people's protected characteristics, goals and desired outcomes, as well as identified health-related needs. Staff told us they got to know people as they supported them but could not share this level of information about people.

● We found multiple examples of inconsistencies and insufficient guidance within people's care records and within this, minimal evidence of people's expressed choices and wishes for their care. Systems did not ensure people's preferences and wishes could be effectively gathered and consistently met.

● A staff member described their concerns when they first joined about the lack of significant information in people's care records. They told us this had improved and informed better care. "In the COVID-19 unit, no information was passed on about people's needs, it's really important for staff to know if someone has a DNACPR in place. If something happened, you don't want to be running around trying to find the information." We raised this with the provider and sought immediate assurances that accurate information would be gathered and shared with staff.

● People stayed at the service for short periods of time, often following a hospital stay and for reasons related to COVID-19. People's feedback reflected that the support at the service was satisfactory but ultimately, they expressed wanting to recover and return home. A staff member told us, "I feel we are doing as much as can to support people given the circumstances [of COVID-19]. We are here to care and nurse so that should be our first and foremost."

● The provider and manager told us improvements were underway to care planning processes and that record keeping did not demonstrate the positive ways people's needs had been met.

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

● At the time of the inspection, visitors were not allowed to the service except in extenuating circumstances due to the risks associated with COVID-19. Although some people had ways of keeping in touch with loved ones, such as online or over the phone, the service had not helped ensure this could be a consistent experience for all people and their loved ones as far as possible. The provider acknowledged they had not done enough to keep relatives and loved ones informed and told us this had been improved after our inspection.

● There were not enough activities at the home or support in place for people to pursue their interests as far as possible at the time of the inspection. One person told us, "Activities? There's nothing, but I don't want to do anything anyway, I just want my puzzles." An activity coordinator had recently been recruited. After our

inspection, the provider told us after completing self-isolation, people had enjoyed socially distanced meals together, crafting and baking.
● The majority of people were isolating in their rooms at the time of the inspection due to concerns associated with COVID-19. Staff and relatives told us people had books and televisions to keep themselves going. A staff member told us, "Nearly all the rooms have radios and the home has ensured all rooms have a TV… Families are very good, they tend to ensure people have books to read, puzzles, magazines." Staff told us they spent time chatting to people when supporting them too.

Improving care quality in response to complaints or concerns
● Complaints processes were not used effectively to help improve the quality of the service.
● Relatives' feedback showed they were not aware of how to use the provider's complaints processes. One person told us they had been told to speak to staff and raise any concerns they had but they also were not familiar with the complaints process.
● Complaints logs were not used as planned and records did not help demonstrate how complaints had been used for learning and improvements to the service. The new manager had reviewed the complaints the home had received and told us they had followed up on these with the people concerned.

End of life care and support
● People's end of life care plans we sampled were basic and did not state the person's wishes and preferences for how they wish to be supported at this stage of their life.
● We saw a compliment had been shared with the service about how one person was supported at the end of their life.
● Management were aware of two people who were at end of life and were closely monitoring their needs and any further support required.

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.
● We were told nobody using the service required this support at the time of our inspection. We received no information to suggest this was inaccurate.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- Despite the provider's role in the local response to the pandemic and supporting people with COVID-19 at the time of the inspection, we identified significant shortfalls in infection control practice and the provider's failure to follow national infection prevention and control guidance. The provider had failed to ensure their systems were fit for purpose to protect people and staff.
- The provider had failed to ensure adequate systems and facilities were in place to allow for safe infection control measures. This included lack of infection control audits, adequate cleaning schedules, unsafe facilities and storage for personal protective equipment, and failure to assess the needs and safe deployment of staff. The lack of oversight from the provider meant these shortfalls in the safety of the service were not robustly addressed, despite us bringing the concerns to their attention.
- After the first day of our inspection, we were told that immediate action would be taken to address the inadequate infection prevention and control measures in place. On the second day of our site visit, we found further concerns and additional risks in relation to how COVID-19 related risks were being managed.
- Systems failed to ensure additional risks presented to people were adequately assessed and mitigated against. We found numerous examples where people had poor and incomplete risk assessments. This, combined, with core training not being provided as planned for new and incoming staff, showed systems did not help ensure people's needs were always effectively met.
- Incidents that had occurred at the service, such as a number of falls, were also not sufficiently reviewed to help identify any possible trends and how to prevent similar risks in future.
- Medicines audits were not in place at the time of the inspection and multiple shortfalls which put people at risk of unsafe care had been identified and addressed until we brought this to the attention of the provider and local authority.
- We saw that numerous records related to people's care were poorly maintained and failed to accurately detail how to appropriately meet people's needs and preferences. Audits were not in place to identify and address these shortfalls which put people at continued risk of poor care.
- Some staff feedback showed that inconsistent and poor admissions planning could impact the quality of people's experiences and care planning. The new manager told us that the swift turnaround of admissions and departures from the service was their immediate priority to address. Following our inspection activity, the manager told us the provider was voluntarily stopping admissions to the service to allow time to address this and to build in safer systems. The provider had not established adequate systems to have proactively identified and addressed these significant concerns.
- There were no systems to effectively assess, monitor and improve the service, including people's

experiences. The provider had no effective means to involve people in discussions and reviews about their care and individual preferences.
● The provider had surveys for gathering feedback from people using the service, relatives, visitors and other stakeholders but had not distributed these. This was a further lost opportunity to gather and use feedback to support improvements to the service.

Due to poor governance of the service people were placed at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● The provider understood their regulatory requirements yet they had failed to implement adequate governance systems to ensure care did not fall below fundamental standards of care.
● A new clinical lead and manager had joined the service in recent days before the inspection and acknowledged the areas of improvements required. After the inspection, the local authority advised us of ongoing improvements underway by the manager and nominated individual.
● We had received notifications from the provider regarding specific incidents and events as required.
● There had been numerous changes in management since the service opened which meant new systems were frequently introduced and changed again. One person told us, "There's been a lot of turnover. All the time there's new faces it's not good. But I can't fault the staff they are great." One staff member told us, "There's been lots of managers and they all ask for changes." This meant improvements could not be embedded and sustained to ensure consistently good care.
● The new manager, who joined the service on the day of our inspection, demonstrated understanding of the principles of good quality assurance, acknowledged and agreed with the concerns we raised, along with the nominated individual. After our inspection, the provider provided us with further assurances and evidence, which included preventing admissions to the service while they addressed areas of concerns. We also followed up on our concerns through enforcement activity and received assurances from the local authority's involvement to support ongoing improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Engagement with the relatives was poor and relatives described only hearing from the service if their loved one was involved in an incident such as a fall. Comments included, "There was no newsletter or emails. We sometimes struggled to get through," and "They said "Anything you need to know we will call you" I felt they didn't want us calling all the time. We call them, they don't call us. I feel we've kept them in the loop they haven't kept us in the loop… when you do speak, they are pretty good."
● Our sample of records and discussions with relatives confirmed the service's communication with people's loved ones was reactive and minimal. After our inspection, the manager described they had recognised and implemented the improvements needed in this area.
● Staff said they could share their feedback and ideas with management and that this was acted on. However there were no processes in place to capture this feedback, for example to ensure it was acted on consistently and promptly and to support ongoing improvements to the home.
● COVID-19 related risks posed to staff had not been assessed to fully consider the needs of the staff group and we prompted the provider to take this action to help protect their staff.
● Staff spoke positively about their colleagues and the service management and described enjoying their roles. Comments included, "Everyone has time for residents," "It's caring and protective", and "The carers are excellent. I know I'm a carer saying that but it's true, it's a really good team."

Working in partnership with others

● We raised concerns with the local authority about our inspection findings. During the time of our inspection and afterwards, relevant partner agencies worked with the provider to help drive improvements to the safety of the service. Before the inspection, the provider had not been supported and enabled as far as possible through partnership working.

● Staff said they had suggested improvements that were needed and these were often taken on board by the provider. One staff member told us, "There's been a lot of changes and systems put in place and I do believe it's running better than when I first came here." We saw a, 'You said, We did' display intended to share how feedback had been used to improve the service, however no actions or updates were listed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Due to widespread and significant shortfalls in the safety of the service, people were placed at ongoing risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Warning Notice against the registered provider, requiring the provider to become compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by a set deadline.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Due to poor governance of the service people were placed at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Positive conditions were added to the provider's registration. Audits must be in place to ensure records and assessments are accurately recorded. The needs and preferences of all people in the provider's care must be recorded and analysed and to assess the quality and safety of the service in relation to incidents, accidents and risk.