G & A Investments Projects Limited

Oakwood Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Oakwood Residential Home is a residential care home providing personal care and accommodation for up to 28 people. The service provides support to older people and those who may be living with dementia. At the time of our inspection there were 21 people using the service. Accommodation was spread over two floors accessible via a lift.

People's experience of using this service and what we found
At this inspection the provider had failed to address the breaches of regulation identified at our previous inspection in August 2022. The provider had submitted an action plan following the last inspection but had failed to make or sustain improvements in these areas.

Systems to oversee the quality and safety of the service were not robust or effective throughout all levels of management. The provider did not maintain effective oversight of the service to support the manager to meet their responsibilities around providing good quality care.

Governance processes and systems had not identified all the concerns we found. Medicines were not being properly and safely managed including controlled drugs. There were omissions and errors, a lack of stock control and monitoring, lack of training and effective auditing. Systems to identify and mitigate risk were not effective. People were at increased risk of harm due to poor infection control procedures. Risks related to the premises were not safely managed, this included risks related to fire safety and Legionella.

The provider did not ensure recruitment checks were carried out in line with the regulations. People were at increased risk of being cared for by staff without the knowledge and skills to fulfil the requirements of their role. Staff did not always receive training or training updates in line with their role. There were significant numbers of staff who required or were overdue updates in key areas relevant to their role, such as medicines; mental capacity; moving and handling; fire; safeguarding adults; first aid, infection control, food hygiene; dementia; end of life care and health and safety.

People's assessments and care plans were not always accurate or complete. People's care was not always personalised. Further work was required to reduce the risk of people experiencing social isolation through personalised activities. The home environment did not reflect dementia friendly best practice to best meet people's needs.

Systems and processes to safeguard people from the risk of abuse were not effective. The provider did not always report allegations of abuse in line with safeguarding requirements. This resulted in an increased risk of harm to people. Lessons were not always learnt when incidents occurred to reduce the risk of re-occurrence.

We found the principles of the Mental Capacity Act 2005 (MCA) were not always followed, for example in

relation to the use of bed rails, care and treatment and medicines. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible, and in their best interests; the policies and systems in the service did not support this practice.

People told us they felt safe. We received mixed feedback from relatives including, "Yes, just about safe. Staff go into [relative's] room to check them minimally and don't check regular" and "Yes [relative] is safe from what I've seen."

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 1 November 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service and in part due to concerns received about risk management and staffing. A decision was made for us to inspect and examine those risks.

We 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.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

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

Enforcement
We have identified the provider failed to fully address the action we told them to following our last Inspection. There were continued breaches in safe care and treatment, staffing and fit and proper persons. We have identified further breaches in relation to person centred care, dignity and respect, need for consent, safeguarding, premises and equipment, good governance and failure to notify at this inspection.
Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Oakwood Residential Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was completed by 3 inspectors and 2 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oakwood Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oakwood Residential Homes is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been appointed and had been in post 6 weeks. An application to register as manager of the service had not yet been received.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with 7 people and 14 relatives of people who used the service about their experience of the care provided. We spoke with 12 members of staff including the manager, care staff, kitchen staff, housekeeping and maintenance.

We reviewed a range of records. This included 8 people's care records and multiple medicines records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits and policies and procedures were reviewed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● An external fire risk assessment completed in September 2022, identified several significant findings. There was no documentation showing the required actions had been completed and some of the issues found on this inspection were the same as the concerns raised in the external report. Therefore, not all action had been taken in reducing risks related to fire safety.
● We found doors with holes in them, missing intumescent strips, doors which were not fire rated; this meant fire protection for these doors would have been reduced. Not all cupboards and void spaces had fire detection; this meant the fire alarm system would not have detected a fire in those areas. A yearly gas safety certificate had not been carried out since 2018. Staff told us they did not receive simulated fire drills. The provider could not be assured that staff were competent to safely manage an evacuation in the event of an emergency.
● Risks related to the water temperatures were not safely managed. For example, high water temperatures were consistently being documented in two bedrooms with temperature recordings of up to 58°. For example, thermostatic mixing valve (TMV) records showed that a bedroom recorded a temperature of 58° in March 2023, this was indicated again in June 2023 with a record stating 'requiring TMV' however no action had been taken. This placed people at increased risk of burns and scalds. We were not assured that risks related to Legionella were effectively being completed, the manager was unable to provide further information if all immediate actions had been taken when identified.
● Individual risks to people were not always assessed, such as for the use of bed rails. One person had no risk assessment in place for bedrails and another person had a generic risk assessment. However, this did not identify and mitigate potential risks around entrapment and entanglement. There were no emollient risk assessments in place for people who were prescribed topical creams, certain prescribed creams indicate a flammable warning on the tub and can pose an increased fire risk. For example, a smoking risk assessment for a person did not contain information of the emollients they had prescribed and applied to the body.
● Where a person had been assessed as needing regular repositioning due to the increased risk of developing pressure sores, care records contained significant gaps and did not confirm this was being completed as assessed. There were no records of monthly Waterlow risk assessments being completed as

described in the person's care plan. District nurse records described an area of pressure injury for a person and the person's care record did not mention this.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to the significant and widespread concerns around fire safety, we escalated this to Hampshire and Isle of Wight fire and rescue service.
●Due to the level of concern for people who required repositioning, we made a referral to safeguarding.

Staffing and recruitment

At our last inspection the provider had failed to have robust effective recruitment to ensure that staff were of good character and had the qualifications, competence and skill to carry out care and support appropriately and safely. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19

● Recruitment checks were not always carried out in line with the regulations. The provider's recruitment policy did not meet the requirements of Regulation 19.
● At our last inspection in August 2022, not all staff had satisfactory evidence of conduct in previous employment in health or social care, with children or vulnerable adults. Staff had started to work with people before these assurances were obtained. During this inspection we reviewed recruitment records for 4 staff. All 4 records indicated the provider did not always carry out appropriate recruitment checks on staff before they supported people. From the information the manager supplied it indicated 32 staff were employed at the service.
● One staff record did not contain proof of ID, right to work in the UK, incomplete employment history, satisfactory evidence of conduct in previous roles relating to health and social care, or children or vulnerable adults, interview questions or evidence of an enhanced Disclosure and Barring Service check in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Another staff member did not have a full employment history from leaving school so gaps could not be explored, there was no satisfactory evidence of conduct in previous roles relating to health and social care along with no evidence of leaving the previous role and a DBS that was only authorised 3 weeks after they had started work in the service. A risk assessment had been completed for the staff member to start work in the service prior to the DBS clearance however, this was dated after the DBS was cleared.
● Another staff member did not have a full and complete employment history or satisfactory evidence of conduct in previous roles relating to health and social care.
● We reviewed records for 2 staff who were due to start working at the service soon and found very limited information contained within their recruitment files. There was no evidence of references being applied for or DBS applications being made.

The failure to ensure appropriate staff recruitment processes were in place and carried out. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● We received mixed feedback from people and relatives when asked if there were enough staff to get the care they needed when they wanted it. Feedback included, "Sometimes they're a bit short, but mostly it's all right. There's three on at night and that's enough", "There is some turnover of staff. There seems always to be somebody new when I visit", and "Staff turnover is high. I see lots of new faces".

Using medicines safely

● Medicines were not managed safely and records were not accurately maintained. People were not supported by trained and competent staff. There were 7 staff administering medicines. 6 of these staff did not have up to date training and had not been assessed as competent to administer medicines. This put people at risk of harm as the provider could not be assured staff had the required skills and knowledge to ensure safe medicine practices.

● People did not always receive their medicines as prescribed. On day 1 of inspection at 12.45pm, we raised a concern to the manager as 6 people had not received their 8am medicine. On day 2 of inspection at 15.45pm the inspector again brought it to the managers attention that a person had not had their 8am medicine. This evidenced that people were not receiving their medicines as prescribed .

● Controlled drugs (CDs) are medicines that come under strict legal controls. The CD register contained errors, lacked essential information and CDs had not been accurately signed into the building. We found a record of CDs being in the building when they were not. There was no auditing or checking the stocks of CD's. The systems in place were not in line with the legal requirements for controlled drugs.

● One person did not have a weekly pain patch applied as prescribed for a period of 7 days on 7 separate occasions in a 6 month period, which meant they may have experienced avoidable pain during these periods. Where people were prescribed the use of a transdermal patch the area of the body the patch was applied too was not always being alternated. This could lead to an increase in adverse reactions or potential overdose of a medicine.

● Stocks of medication were not managed safely to ensure people had an adequate supply of their medicines. The staff did not record if any tablets were brought forward from the previous cycle. This meant it was not possible to carry out effective audits. There was no evidence of regular auditing or stock checks of medicines. We identified times where medicines had not been available as they were out of stock and people did not receive their medicines as prescribed.

● PRN guidance was inconsistent and did not always reflect the prescribers instructions. For example, a PRN protocol for a person's prescribed paracetamol states 'Take 2 tablets up to 4 times a day' however, the Medicines Administration Record (MAR) states, 'One to be taken 4 times a day'. This put the person at risk of not receiving their medicines as prescribed. There was insufficient recording as to why PRN medicine had been administered or if it had been effective. This information is required for monitoring a person, determining the effectiveness of the medicine and deciding if they needed reviewing by the doctor.

● Topical medicines were not being stored securely. People's prescribed topical creams were observed left in a communal bathroom and were not being kept securely to ensure people could not access them and put themselves at risk of accidental harm.

● After the inspection the provider sent evidence that staff had since received medicine training and competencies had been assessed.

People's medicines were not being properly and safely managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We requested immediate assurances from the provider in relation to staff training and the significant

concerns we had identified.
● Due to the level of concerns around medicines, we made a referral to safeguarding.

Preventing and controlling infection
● There were concerns with infection control within the home. There were areas of the home that were not clean, the laundry was visibly dirty, large cobwebs around windows and some carpeted areas were worn and in need of a deep clean.
● Infection prevention and control (IPC) practices were not all followed. For instance, mops were found in dirty water and not stored in line with guidance, mop heads that were black with dirt were being used, clinical bins within the toilets were not pedal operated.
● We observed staff going outside for regular cigarettes then re-entering the building and continuing work without washing their hands. We observed staff wearing false nails and nail varnish. This did not meet current infection prevention and control guidance.
● The training matrix indicated 32 staff employed. There were 21 staff who had not received or were out of date with infection control training. This training ensures staff have the required knowledge to minimise risks to people.
● We observed a person laying in bed with their catheter bag hanging in a plastic tub on the floor at the foot of the bed. We observed staff walking through the lounge without wearing gloves and apron carrying soiled clothing in a red bag.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.

The provider had failed to protect people from the risk of infection and cross contamination. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not always kept safe by the use of an effective safeguarding system. Safeguarding concerns were not always fully recorded and appropriate actions were not always identified to promote safety. For example, allegations of abuse were not always reported to the local authority and records were not always completed with management actions. An incident report completed by staff referred to a resident victim as "unsure who". This meant people were at risk of harm.
● There was evidence that a person had restrictions on their movement and the provider did not act in accordance with the relevant codes of practice. This included the arrangements for a person who received care in bed and required restrictions around their movement for safety reasons. We found the provider had not followed the correct process in obtaining the legal authority to impose these restrictions.
● Not all staff were up to date or had received safeguarding training. Staff we spoke to were not always able to go into detail with regard to the safeguarding processes. This meant the provider failed to keep people safe through a lack of required concern escalation.
● Lessons were not always learned when things went wrong. Accidents and incidents were recorded, but these were not always complete and did not always include what actions were taken, analysis, management reviews, or any management plan in place to prevent re-occurrence.
● Staff were given limited opportunities to reflect on incidents and share learning, therefore there was not always a consistence approach to analysing and reducing the risk of re-occurrence.

The provider failed to protect people from improper treatment and abuse through the use of effective systems and processes. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

- During our inspection we saw visitors arriving and visiting their relatives in the home.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

At our last inspection in August 2022, the breach of Regulation 18 was inspected within the safe domain which was a focused inspection covering the key questions of safe and well-led only. This found there was not a robust effective system in place to ensure that the provider employed people who were suitably qualified, competent and experienced. This placed people at risk of receiving inappropriate or unsafe care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

- Staff did not always receive training or training updates in line with their role. There were significant numbers of staff who required or were overdue updates in key areas relevant to their role, such as medicines; mental capacity; moving and handling; fire; safeguarding adults; first aid, infection control, food hygiene; dementia; end of life care and health and safety.
- Not all staff had training, or in date training, to ensure they met the needs of people with specific conditions such as catheter care, Parkinson's and behaviours that may challenge.
- The training matrix indicated out of 32 staff employed 26 staff had not received or were out of date with mental capacity training. Not all the staff we spoke to had a good knowledge or understanding of the Mental Capacity Act 2005.
- 18 out of the 32 staff on the training matrix had not received or had out of date training in equality and diversity. Twenty out of the 32 staff had not received or had out of date training in privacy and dignity.
- The provider failed to ensure staff were supported through supervision or performance monitoring. It was evident from the staff files that we reviewed that staff had not received managerial supervision. We spoke to 7 staff in relation to supervisions who confirmed this. Comments included, "I can't say that I've had a supervision since I've been here", "Not really" and "No, I think if we asked, we would get it". This meant the provider could not be assured that staff performance was safe.

The provider failed to ensure staff received appropriate training. This was a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when
needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where people had a condition of the mind or brain which may affect their mental capacity to make specific decisions, the provider had not undertaken mental capacity assessments (MCA). There was no evidence people were provided with relevant information to support them to make specific decisions, such as the options, risks and benefits, or to show how the decision made was in their best interest, if they lacked the capacity to make it.
● People had restrictive measures in place without documenting their consent or demonstrating they lacked capacity to consent through an MCA. The provider could not demonstrate restrictions in place were in people's best interest as there was no evidence of involvement of people, their relatives or those lawfully acting on their behalf to make those decisions. These restrictions included the use of bed rails and floor sensor mats which could limit the person's privacy and freedom of movement in the home.
● There were no MCA and best interest decisions for other specific decisions made on behalf of people such as consent to personal care, medicines and modification of diets.
● Consent was not always obtained or established correctly – the consent forms we reviewed within folders were not always completed or signed by people or a person who have legal authority to do so.

The provider failed to act in accordance with The Mental Capacity Act 2005, when people were unable to give consent due to a lack of capacity. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● On day 1 of inspection we found window restrictors were not in place on many windows in bedrooms, bathrooms and communal areas at ground and 1st floor levels, these areas were accessible to people who are living with dementia. We brought this to the attention of the manager however, on day 3, these were still not in place nor were measures taken to ensure safety of people for example, to lock the windows until the restrictors were fitted. This placed people at increased risk of harm.
● We found some items of equipment that had not all been maintained and serviced in a timely way causing long delays and impacting on their use for people, such as a mobile hoist. Records indicated there was a 4 month delay in the servicing for a mobile hoist, a bath hoist, and the stairlift. The bath hoist was serviced in April 2023 and failed, this item of equipment was still being used however, it was not clear from the records as to whether the equipment was safe to use as there were no further records. We raised this with the manager on day 1 of inspection who told us the provider had made arrangements for this to be serviced.
● The stairlift had an issue and stopped working in April 2023, the provider acquired a new seating

mechanism and this was fitted by the provider and a maintenance member of staff. The manager confirmed the stairlift was still being used despite there being no assurances as to its safety and no evidence of the provider or maintenance staff's level of competency to undertake this task. We raised this with the manager on day 1 of inspection who told us the provider had made arrangements for this to be serviced.

● We found an area of corridor where 5 screws had raised above floor level and had pierced through the vinyl. This was on a walk through in a busy corridor, this presented an increased risk to trips and falls.
● The home environment did not promote people's choice and independence. For instance, there was a lack of appropriate signage to support people living with dementia to orientate to time and place, the décor was not dementia friendly.

The provider failed to ensure the premises were secure, equipment was properly used and maintained. This was a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● On day 2 of inspection an external company visited the service and carried out the servicing of the stairlift, bath hoist and mobile hoist.
● After the inspection the provider sent evidence that they had taken action in relation to ensuring people's safety with window restrictors.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not effectively use the Malnutrition Universal Screening Tool (MUST) to monitor people's risk of malnutrition. There was evidence people were not being weighed regularly. For example, the monthly weight records for 2 people stated 'unable to weigh' therefore an accurate reflection of weight loss for these people could not be established as MUST, outcomes and actions were not being completed.
● Some people's nutritional plans contained inconsistent information about levels their food and fluid should be thickened to, using the recognised International Dysphagia Diet Standardisation Initiatives (IDDSI). This is important so all staff supporting people to eat, and drink would know what the level was to reduce risks of choking.
● For example, a person's brief care plan stated, 'only to eat fork mashable, soft food or liquid food such as soup but with no bits'. Their main care plan stated, 'soft diet' however at the top of the plan it states, 'normal diet'. The kitchen did not indicate a modified diet. The person's care plan was last updated 6 July 2022. The person's choking risk assessment states 'bite -sized food' however further down indicates that food is not modified. This placed people at increased risk of harm.
● There were support plans in place for people's oral care however, these were very generic and not person centred. It was evident that a person had only received oral health care on one occasion between the period 1 – 10 August 2023. This was raised with the manager.

Supporting people to eat and drink enough to maintain a balanced diet
● People's food and fluid levels were not well monitored. Records contained multiple gaps which did not show people had received regular food or drink. This is a particular risk for those people living with diabetes who needed to eat and drink regularly to maintain their health condition. A relative told us, "Things like keeping records are dreadful. [Relative's] eating and drinking doesn't show how much [relative] has actually had".
● There was no oversight of the records that had been completed to ensure people ate and drank enough.
● However, staff were observed supporting people to eat and drink when they needed assistance and a choice of food and drinks were offered.

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

- There was evidence of working with other agencies such as district nurses and GP's.
- People had access to regular healthcare services such as a weekly nurse visit from the surgery.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last comprehensive inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always respected. Our observations found several people in bed asleep with the doors wide open. For example, a bedroom door was wide open and a person was in bed asleep, this bedroom led onto the corridor where staff and other people were observed walking past as it led to the lounge. This was a lack of privacy and dignity for this person.
- People's bedroom doors had A4 sized frames containing personal information about the person, such as the dates of birth and known allergies. This did not maintain people's privacy/confidentiality as people walking down the corridors could clearly see this sensitive information.
- People's items of personal clothing including nightwear and underwear were found hanging on the back of communal bathroom doors. The clothing found identified the person's initials as written inside. This was a lack of respect for people's property.
- We found a box containing people's personal belongings. This included 7 pairs of glasses, a mobile phone, 4 watches, 2 hearing aids, 2 pairs of earrings, one pendant, 5 rings, one of which was a wedding band. We asked staff who these belonged to and where told they didn't know. Not all care plans we reviewed had inventory's of people's personal belongings.
- We observed a person calling for help and a staff member stating to them "are you looking for [relative], you're not going home no one is coming to get you". This was not respectful and demonstrated people were not always treated respectfully by staff.

The failure to ensure people's privacy and treat them with dignity and respect was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Within other key questions in this report, we have reflected how the provider's lack of oversight, poor or inconsistent care and medicines records, a lack of MCA assessments and best interest decisions and management oversight, has placed people at risk of being negatively impacted.
- Daily records and other records relating to people's care did not always show people received the care they needed. For example, some people's monitoring records showed they did not always receive appropriate nutritional or repositioning support in line with their needs.
- However, people and relatives spoke kindly about staff. One told us, "They (staff) always greet us in a friendly manner", others said, "The [staff] work very hard and they're very willing", and "They're all friendly and sweet".

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

● People's care plans did not demonstrate people and relatives had been asked their views and wishes. Information was not consistently updated; consent was not always sought. This meant the provider could not be assured that information about people's individual needs and wishes was accurate and up to date.

● People's needs were not reviewed regularly. This meant if their needs, wishes and choices had changed, there was a risk these would not be met. For example, a person's care plans had not been reviewed since July 2022.

● Feedback from relatives included, "I'm happy with the service to the best of my knowledge. They don't contact me which is really bad. Unless I ring them".

● There were no meetings organised with people and their relatives. This meant the provider could not demonstrate people had regular opportunities to raise any concerns and be involved in the service development.

Requires Improvement

Is the service responsive?

Our findings

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

At our last comprehensive inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People's care was not always planned in a person-centred way. People did not appear to be involved in reviews around their care. Some care plans had not been reviewed or updated since July 2022. Because people's care plans and risk assessments were not regularly reviewed, there was a risk the staff would not have up to date information and people's needs might not always be met. There were no life histories documented for people in their care plans, no information about the person's history, their likes, dislikes and hobbies, this information can support staff such as in reminiscing activities.
- Care plans were not always person centred, lacked detail and were not in place for specific conditions. For example, a person living with dementia had no detailed information referenced within their care plans to ensure that staff understood how their dementia impacted them as a person and how they were to be treated. For another person living with a long term condition, they did not have a relevant care plan providing guidance to staff on how the condition effected them and how to manage the condition effectively if it exacerbated.
- Care plans did not always have adequate information for staff to provide consistent, person-centred care. One person was prescribed medicine to take when agitated or very anxious. However, the care plan did not include positive behaviour strategies, triggers and diversion techniques. This meant that staff members may not have had the appropriate knowledge required to respond to the person's needs.
- Staff we spoke with said they had not read the care plans, although some staff did say they had read one or two when they first started. This meant that people may not always be cared for in line with their wishes or as the care plan dictated.
- Not all people had end-of-life care plans in place. A person who was on the end of life care pathway did not have an end of life plan in place. This meant that staff did not have a comprehensive understanding of the person's wishes, how they wanted their end of life care to be provided and how to support the person in the best possible way. There was significant gaps in staff training for end of life care meaning not all staff had the skills to effectively support people at the end of their life's.

We found no evidence that people had been harmed, however the support people received did not always meet their care needs. This placed people at risk of harm. 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

- Throughout the inspection we observed a lack of meaningful or stimulating interaction. Some people were spending time with no option of an activity, especially people who spent time in bed as there appeared

to be limited interaction recorded other than task based activities, such as personal care and assistance to eat. There were limited opportunities for reminiscing, occupation or activities to support people in feeling valued.

● The provider contracts 10 hours per week to a member of staff to carry out activities within the home. We observed a quiz on one afternoon and bingo on another. A staff member told us, "Residents love the external singers that come in but this only happens on special occasions such as Christmas".

● Feedback from relatives included, "I think the main problems for [relative] is the loneliness, mental stimulation and conversation", "I'm not really involved in the home. I'm always offered tea and biscuits when I visit. They do events for residents – like the jubilee. But they don't invite family. I don't see too many visitors there", and "Definitely not involved. The family has not been invited".

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs had been assessed and support required was reflected within care plans to help ensure staff knew how best to communicate with people. For instance, if people required glasses or hearing aids to support their communication.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and procedure which detailed how complaints would be managed. However, this needed updating as it was still reflecting the name of a registered manager who deregistered from the service in 2020.

● Relatives told us they could speak with the manager or staff if they had any concerns. Nobody told us of any formal complaints made.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At this inspection there were repeat breaches of regulations relating to safe care and treatment, staff and fit and proper persons. We identified new breaches in relation to dignity and respect, person centred care, need for consent, safeguarding, premises and equipment, good governance and failure to notify.
- The provider's governance system was ineffective in identifying where fundamental standards were not being met or driving improvements where required. They were not robust and did not provide an effective system to systematically identify the continued significant concerns identified on inspection.
- Audit processes were not robust and did not provide an effective system to oversee the quality and safety of the service throughout all levels of management. Some audits were not completed, whilst it was not clear from completed audits how issues and actions were followed up to promote improvement. For example, the provider had not identified the significant concerns with assessing people's capacity and ensuring care was least restrictive of people's freedoms. Care plan audits were recorded to be completed monthly however the last audits documented were April and May 2023. These audits were not effective as they did not identify the issues we found on inspection.
- The provider had failed to maintain an accurate, complete and contemporaneous record in respect of all people living in the service. This included records of the care and treatment provided to people, and of decisions taken in relation to their care. The provider had failed to fully assess, monitor and mitigate the risks relating to the health, safety and welfare of all people and others at risk as described in other sections of this report.
- The provider failed to complete effective infection prevention and control checks on the building, equipment and the practices of staff. They failed to identify or mitigate risks from poor practices which put people at the risk of harm from infection. Policies and procedures were not up to date and in line with good practice guidance. For example, the infection prevention and control policy was last amended November 2017.
- The provider failed to check people had received their prescribed medicines as directed and they failed to ensure protocols for the safe administration of "when required" medicines were completed. This put people at the risk of harm from inconsistent medicine administration. The provider failed to check people's topical medicines were safely stored. This put people at the risk of harm.

Failure to ensure systems were in place to monitor and mitigate risks to people and maintain accurate and complete records is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider did not always comply with their legal responsibilities. Statutory notifications were not always sent to CQC when required. This included several allegations of abuse of all parties and medicine errors.

Failure to notify is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People did not receive dignified, person-centred care and improvements were needed to develop the culture at the service.
● The provider failed to promote good outcomes for people as people's care was not always planned comprehensively, and it was difficult to tell if people received the support they needed.
● We received mixed feedback in relation to the service being well managed. Comments included, "New manager seems pleasant enough", "The atmosphere in there is not too bad. The carers let you in and are bright and breezy. It's reasonably nice going in but the experience inside is negative", and "I think they do the best they can in difficult circumstances. Staff never lose their temper".
● Staff told us they felt the new manager was approachable and fair. One staff member told us, "[Manager] is firm but fair. Which is good".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● We were not provided with evidence that legal responsibilities under the duty of candour had been completed where this was due. We found examples of medicines errors and incidents that would have met the threshold under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were no records of meetings with people or relatives to gain their views about the home. Feedback from relatives included, "Oh no. I'm not aware of or involved in any meetings. I've not had a questionnaire from the home", "I don't think there has ever been any meetings. Never heard of it. I'm not aware of any questionnaire" and "There's been no meetings since Covid. No, I haven't done any questionnaire".
● There were no records of quality assurance surveys being provided to staff, people, relatives or other professionals to understand their experience of the service. Feedback from people and relatives confirmed this. The manager told us that this has not happened.
● Staff we spoke to confirmed that one staff meeting has taken place. Comments included, "Yes. I do feel like a lot of things got said that people wanted to say. Beneficial if more often" and "Since I've been here one senior and one staff with [manager]. Not had them before".
● Records did not show that staff were receiving supervisions. Supervisions are opportunities for two-way conversations. Staff confirmed this, comments included, "I can't say that I've had a supervision since I've been here" and "Nothing formal or written down".

Continuous learning and improving care; Working in partnership with others
● The provider could not demonstrate continuous learning and improvement. The breaches in regulation which were identified at the last inspection in August 2022 remained in breach. New breaches in regulation were identified on this inspection.
● There was no analysis being undertaken by the service in relation to incident and accidents which meant trends were not being identified.
● Records confirmed a range of healthcare professionals had been involved with people's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to notify is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found no evidence that people had been harmed, however the support people received did not always meet their care needs. This placed people at risk of harm. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to ensure people's privacy and treat them with dignity and respect was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in accordance with The Mental Capacity Act 2005, when people

were unable to give consent due to a lack of capacity. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from improper treatment and abuse through the use of effective systems and processes. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the premises were secure, equipment was properly used and maintained. This was a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure appropriate staff recruitment processes were in place and carried out. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate training. This was a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014

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 Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. People's medicines were not being properly and safely managed. This placed people at risk of harm. The provider had failed to protect people from the risk of infection and cross contamination. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The enforcement action we took:

Serve a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure systems were in place to monitor and mitigate risks to people and maintain accurate and complete records is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Serve a warning notice