Dudley Court Care Limited

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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
Dudley Court Care Limited is a residential care home providing personal and nursing care to 19 people aged 65 and over at the time of the inspection. The service can support up to 22 people in one adapted building.

People's experience of using this service and what we found
This inspection found the provider had failed to adequately monitor and improve the quality and safety of the service and to ensure compliance with the regulations. We found the provider had failed to address numerous areas of improvement identified at the last inspection in May 2018, and to proactively address other concerns which also put people at risk of unsafe care and inappropriate care, and failed to meet people's needs and preferences at all times.

Systems failed to protect people from harm and unsafe care at all times. We found the provider was in breach of the regulations because their systems failed to ensure incidents and safeguarding matters would always be appropriately dealt with to protect people. We identified another breach of the regulations because people's risks, including those presented by the provider's poor upkeep of the premises, were not always safely managed.

We identified a further breach of the regulations because care planning processes failed to ensure all people's needs, wishes and preferences could be gathered and met as far as possible including in relation to dementia care, end of life care and to promote good access to activities.

People felt their rooms were clean however systems did not ensure good infection control practices at all times. Systems did not always ensure there were always enough staff to meet all people's needs. A recent staff recruitment check had been carried out safely however improvements were still required to how recruitment records were maintained. People were supported appropriately with medicines and systems promoted safe practice however some improvements were still required.

People's needs were not all effectively assessed and reviewed to ensure effective support was always provided and in line with current good practice. Staff did not all feel supported. Training gaps identified at the last inspection were still being addressed. People gave positive feedback about their rooms however improvements about the design and décor of the home from the last inspection had not been fully addressed. People generally spoke positively about their support including meals, and confirmed they were supported to access healthcare services as needed. People were not supported to have maximum choice and control of their lives as far as possible and staff did not always support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support good practice.

Although people's feedback reflected some improvements had been made, staff were still not consistently caring, and practices did not always promote people's independence, dignity and positive experiences as far as possible. People were still not involved in discussions and decisions about their care where possible to

ensure their individual needs were known and met and to improve the quality of their care. People felt they could ask for the support they needed, and people and relatives felt able to complain, however, such feedback was not always used effectively to improve the service.

We identified a repeated breach of the regulations from the last inspection because the provider's systems and processes failed to effectively assess, monitor and improve the quality and safety of the service and the quality of people's experiences. Our inspection identified a further two breaches of the regulations due to the provider's failure to meet regulatory requirements to display their inspection ratings and to inform the Commission as required about events including possible safeguarding matters.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

For more details, please see the full report which is on the CQC website at
Rating at last inspection
The last rating for this service was Requires Improved (published 01 August 2018).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was still in breach of regulations. The overall rating of the service has deteriorated to Inadequate.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
At this inspection, we have identified repeated breaches in relation to good governance, the provider's failure to display ratings as required and to always notify the Commission as required. The inspection also identified breaches in relation to safeguarding service users from abuse and improper treatment, person-centred care and safe care and treatment. 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; Special Measures
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. We will work alongside the provider and 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

Dudley Court Care Limited

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 an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Dudley Court Care Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The provider is required to have a registered manager, however, the registered manager had left in October 2018. The previous assistant manager had become home manager but was not registered with the Care Quality Commission. The inspection feedback was shared with the provider after the inspection because they were not present during the site visit. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with five people living at the home and two relatives about their experience of the care provided. We spoke with six members of staff including the manager, senior care assistants, care assistants and the cook. 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. We also spoke with four professionals with input and/or oversight of people's health care and a reverend who regularly visited the service.
We reviewed a range of records. This included records related to seven people's care records and a random sample of medication records. We looked at one staff file in relation to recruitment for the new staff member who had been recruited since the last inspection. We sampled a variety of records relating to the quality of safety of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and staffing rotas. We continued phone calls with staff and healthcare professionals as part of our inspection processes as described under 'during the inspection'.

Ongoing/ continued breaches
Improvements have not been made and the provider is still in breach of regulations.

Our last inspection identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to governance. This inspection found the breach had not been met. This was because governance systems failed to effectively assess, monitor and improve the quality and safety of the service.

Our last inspection also identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the provider had failed to notify us of events as required. The provider had failed to improve systems to ensure relevant incidents were shared with relevant partner agencies. This presented an ongoing risk that we would still not be notified of all events as required.

New breaches
This inspection identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment. This was because people's risks including equipment use and fire safety were not effectively managed at all times.

This inspection identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding service users from abuse and improper treatment. This was because allegations or concerns of abuse were not all responded to in line with the provider's safeguarding policy.

This inspection identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care. This was because poor care planning processes failed to gather and meet people's care needs and preferences.

This inspection identified a breach of Regulations 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to display their current inspection ratings as required.

Follow up recommendations

At our last inspection, we made a recommendation for the service to take steps to ensure all safety incidents are recorded, reviewed and learned from, and measures implemented to reduce risks to the safety of people living at the home. The provider had not made improvements which led to concerns that contributed to breaches of the regulations.
We prompted the provider to address immediate concerns including referrals to the local safeguarding authority. We also shared our concerns with the local authority and fire service after the inspection. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection in May 2018 this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse;
Learning lessons when things go wrong

- Information we checked before our inspection found safeguarding matters were usually escalated and shared with the Commission as required. However, systems did not ensure all incidents were appropriately responded to, to help protect people.
- The provider had not taken sufficient action to meet our recommendation made at the last inspection, for all safety incidents to be recorded, reviewed and learned from.
- Despite an ongoing safeguarding investigation at the time of the inspection about a staff member, the staff member had returned to work before the investigation was complete. This was against the provider's safeguarding policy and did not help protect people or the staff member.
- One person had a known risk of making allegations of abuse. The person's allegations were not monitored and logged to protect the person and others about whom they made allegations.
- Some people's records showed they had minor injuries such as bruising. Action had not been taken to identify possible causes to help reduce similar risks to people in future. We prompted for safeguarding alerts to be made because the injuries had not all been investigated to identify what had caused them.
- Staff described some signs of abuse and knew how to report concerns however appropriate action had not been taken in response to the above concerns to help protect people and others.

Systems did not ensure allegations or evidence of abuse were immediately investigated and to prevent abuse of people using the service. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had not all received safeguarding training at the last inspection. This had been addressed.
- People told us they felt safe. A relative told us, "[Person] is much safer than at home."
- Fall incidents had been reviewed for trends. The manager told us this analysis had led to falls clinic referrals for two people.

Assessing risk, safety monitoring and management

- We saw prescribed thickener was not always used safely, to manage two people's risks of choking. Staff gave different information about how drinks should be safely made for each person, and guidance about this was not made clear to ensure people could always be supported safely. We prompted for this to be addressed with input from relevant healthcare professionals. Staff understood how to safely support one person who had relevant guidance in place.
- Risk assessments that were available did not always provide enough guidance for staff to always know how to support all people safely, including for people's known risks such as diabetes and behaviours that

may challenge. Staff knew information about some people's risks and how to help keep those people safe however this was not consistent for all people's risks.
● Health and safety checks had failed to identify and mitigate hazards on the premises which could cause people harm and/or serious injury. We prompted for these concerns to be addressed.
● As found at our last inspection, the provider could not demonstrate safety checks of all people's equipment were carried out, such as airflow mattresses. This had still not been addressed to ensure people's safety and comfort as far as possible.
● People's personal evacuation emergency plans were not readily available in the case of the event of a fire. This was a concern also identified at our last inspection. The manager was aware one person did not have a personal evacuation emergency plan in place since they had joined in June 2019, but had not yet addressed this.
● After the inspection, we shared our findings with the fire service and the provider submitted additional evidence which had not been available during our visit. The fire service later confirmed they were satisfied the provider complied with fire safety legislation.

The provider had failed to ensure people's risks were assessed and to take reasonable action to mitigate risks including ensuring the safety of the premises, equipment and in case of the event of a fire. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Staff had not received fire safety training at the last inspection. This had now been addressed. Staff confirmed they took part in fire drills and understood what would be expected of them.
● We saw evidence of other necessary fire and equipment safety checks including lift certification.
● Staff were often aware of most people's risks and how to help keep people safe, for example, signs to look out for if people were unwell and who to contact.

Staffing and recruitment
● Improvements were still required.
● People's feedback showed they felt they did not have to wait long for support. Comments included: "There's always someone in [a lounge area]. I use my call bell sometimes and I don't wait too long," and, "I think there are [enough staff]. They can be helpful, there isn't much time for a chat." However, as at our last inspection, people told us staff did not always have time to speak with them. The manager told us they had plans to recruit a staff member to lead on activities and to spend time with people.
● One new staff member had been recruited since the last inspection and we saw continued evidence that safe recruitment checks were carried out before staff started in their roles.
● Our last inspection found improvements were needed to how Disclosure and Barring (DBS) checks were stored. This had not yet been addressed. The manager told us this had been addressed after this inspection.
● We also prompted for the provider to refer to guidelines with the support of the local authority in relation to recruitment checks as staff did not have further DBS checks after joining the service. This would help ensure people were always supported by staff who were suitable.

Preventing and controlling infection
● As at our last inspection, we saw evidence of poor upkeep and hygiene including chipped plaster, peeled wallpaper and some people's bedroom doors were dirty and discoloured.
● We detected odours in parts of the home throughout the day. This included a toilet area for which air freshener facilities were not used. We raised this with the manager. Audits had not identified these issues and methods to address odours and possible hygiene and infection control concerns.
● Staff told us they used personal protective equipment although we informed the manager that a staff member wore excess jewellery. The staff member told us they had previously been advised not to wear excess jewellery because this did not promote good hygiene practices. After the inspection, the manager

confirmed they had carried out supervision with this staff member.
● All people we spoke with told us their rooms were kept clean. One person told us, "It is clean here my bed is very nice."
● The manager had introduced a new infection control audit since the last inspection and the majority of staff had received recent Infection Prevention and Control training.

Using medicines safely
● People told us they received their medicines on time and we saw appropriate support was given.
● One person told us, "I take tablets, the staff give them to me. If I needed a painkiller I would ask." We saw people were offered pain relief in case needed.
● People's medicines and records were stored securely.
● Medicines administration records we sampled were completed appropriately and correlated with medicines stock levels. We still found some record keeping issues as at our last inspection, for example in relation to one person's 'as and when' (PRN) medicines and another person's pain relief patches.
● A healthcare professional told us medicines were ordered on time.
● An external audit by a clinical commissioning group in February 2019 had found positive medicines management overall.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.
At the last inspection in May 2018, this key question was rated as Requires Improvement. At this inspection this key question has remained at the same rating of 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;
● As found at our last inspection, people's care records did not contain enough guidance to inform good care in line with people's needs and preferences. This did not demonstrate people's needs were assessed and to ensure staff knew how to provide effective care in line with people's needs and current good guidance.
● Improvements had not been fully addressed, for example, with regard to the care for a number of people who were living with dementia. People did not have dementia care plans and staff had still not received training and support to help meet the needs of people living with dementia. We also found little evidence of how areas such as activity planning and the design and décor of the home acknowledged current good practice guidelines.
● We had to tell staff a person was upset as nobody had noticed. The person was not effectively reassured and was told to 'Cheer up'. The person was upset again a few moments later. Comments to us from another staff member showed a poor understanding of this person's needs and the needs of people living with dementia. We shared this concern with the manager.
● People who required less support gave generally positive feedback about the service and staff. One person told us, "They seem busy but seem to know what they're doing." We saw staff often responded positively and in a friendly way to people's requests for support.

Staff support: induction, training, skills and experience
● At our last inspection we found the provider had not provided their own training to staff and the majority of staff training deemed mandatory was incomplete. Staff had since received training in safeguarding, infection prevention and control, fire safety and safe moving and handling support.
● However, staff had still not received dementia care as at the last inspection, and only some staff had received training about person-centred care and people's nutrition and hydration support needs.
● Staff gave mixed feedback as to whether they felt supported in their roles. Some staff said they did not feel they had enough guidance and leadership for their roles.

Supporting people to eat and drink enough to maintain a balanced diet
● People's choices about meals were not promoted as far as possible. People and staff told us the cook selected people's lunch menus. Two people told us they were still served vegetables that they had previously told staff they didn't like. One person told us, "The food is good. There isn't a choice usually but today we were offered one?"
● People gave generally positive feedback about meals. One person said there was plenty to eat and we saw meals were well presented and had good portions. People told us they were regularly offered drinks, as we

saw.
● The cook knew people's dietary requirements and if people needed additional support for example if people had lost weight and needed more encouragement to eat. However we identified safety concerns as people's risks associated with swallowing were not consistently managed and understood by all staff.

Adapting service, design, decoration to meet people's needs
● As we found at the last inspection, improvements had still not been made for the design and décor of the home to be developed around the needs of people living with dementia.
● Our findings such as clutter and potential hazards in areas of the home did not demonstrate the home was well maintained.
● People had been consulted on paint colours for a hallway and bathroom area to involve people and ensure the décor reflected people's preferences. However, these discussions had happened as early as February 2019 and this work had still not been started.
● Some people told us they liked their rooms. One person told us, "I'm happy here in my room. The door is open, I can see who passes by." Some people spent time in their rooms or other areas of the home as they wished which they told us they liked.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● The service did not work within the principles of the MCA as far as possible.
● The service had not ensured people had the means to always move freely and go out as they wished. Some people's walking frames were stored away from them and nobody had been given the keypad door codes to allow those people who could leave, to do so as and when they wished. This did not promote people's freedom as far as possible.
● Staff did not know which people had DoLS authorised and what this meant for their care. People's records did not provide guidance about this and only half of the staff had received MCA training.
● Staff did not all show understanding of the MCA. Some staff failed to recognise one person's rights to make their own decisions about snacking even if staff deemed this to be unwise.
● There was no guidance in any people's care plans we sampled about how to support people to make their own decisions as far as possible, and any decisions taken on their behalf. This was an area of improvement at the last inspection which had not been addressed.

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support
● People told us they were looked after and supported to access healthcare services when unwell and as needed. Staff feedback and records we saw also reflected this.
● One person told us, "The doctor comes in, if I need the doctor I would just tell the staff." The person confirmed they also had access to a chiropodist, dentist and optician as needed.

● Healthcare professionals felt staff knew people well and supported their work.
● Healthcare professional feedback suggested people's skin care was not always consistent to help reduce people's risks although records were accurately maintained at the time of our visit.
● A healthcare professional praised the manager's input to supporting one person living with dementia such as their openness to suggestions and helping to facilitate care reviews.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.
At the last inspection in May 2018, this key question was rated as Requires Improvement. At this inspection this key question has remained at the same rating of 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
● Some people commented staff did not have enough time to talk to them. One person told us, "I think they are kind, there isn't time to chat really, they have such a lot on."
● As at our last inspection, staff did not always take opportunities to chat and spend time with people, for example, although present, we saw staff did not make conversation with people while people quietly waited for their meals with nothing else to do.
● People gave improved feedback since the last inspection about the approach of staff. One person told us, "The staff do seem kind, they're nice to me." A relative told us, "They seem kind enough." We saw some people and staff had good rapport.
● Some staff had received equality and diversity training. Before our inspection, we were told people's care plans were person-centred to help reflect and meet people's protected characteristics. We found people's care plans were not completed to this standard. Although some people's individual needs were recognised by staff, this was not consistent for all people in practice.
● One person's relative told us, "They know [person] quite well. They've tried to learn a few words in [person's language]." Another person's first language was not English. Staff told us staff who shared this language chatted with this person and helped ensure this person could express what they wanted.
● People were invited to attend monthly religious services. A regular visitor told us, "There is a home feel, they were very keen [to have services]. Peoples' spiritual welfare is treated seriously."

Supporting people to express their views and be involved in making decisions about their care
● Our last inspection found people were not involved in discussions about their care. At this inspection, some people and relatives told us they had been involved in developing people's care plans. However, we saw little evidence that people were regularly involved in discussions about their care, their individual needs and decisions about their care after this initial information had been gathered.
● At our last inspection we found the provider had not followed a recommendation made in September 2016 to access current good guidelines about how to support people living with dementia to make decisions. At this inspection we found people's care plans still did not reflect such guidance and how some people could be supported to make decisions about their care.
● These continued areas of improvement did not ensure people's views and preferences were known and met and that people were involved in decisions about their care as far as possible.
● People had completed feedback surveys in January 2019, however this information had not been analysed to help ensure care met people's needs and preferences. Additional surveys had recently been issued. The manager told us they had plans to address some people's feedback they were aware of, and to introduce a system to regularly review all feedback provided.

● One person's records we sampled contained a hospital passport to help others understand their needs and preferences for their care.
● People were invited to monthly residents' meetings and asked for their feedback and ideas about the home.
● People we spoke with felt able to ask for support they wanted from staff and spent their time how they wished. One person told us, "If I want anything I can ask, if I don't feel well I tell them."

Respecting and promoting people's privacy, dignity and independence
● Our last inspection found staff often used task-based language when they referred to people rather than their names. Although we found improvements at this inspection, some staff still used inappropriate language when describing people, such as 'Bedbound' and other descriptions which reflected a poor understanding of a person's conditions and did not promote people's dignity.
● People were given medicines in front of others in communal areas of the home and we saw people were not offered a private space for this support. This was an area of improvement identified in an external audit in February 2019.
● Some areas of the home were not well maintained to promote people's independence and dignity as far as possible. After our inspection, the provider told us the home was being decorated with brightly coloured doors and signage to support some people to navigate around the home independently.
● The manager told us some people chose not to have walking frames left near to them. However, we asked staff why a person's walking frame was stored away from them. Staff told us this was due to less space because of the layout of the home and commented that if the person wanted to move, another person could call for staff using a call bell on the person's behalf. This did not promote people's dignity, privacy or independence.
● One person told us, "They do encourage you. When I wasn't so well, I got lazy and stayed in bed, but they said, 'Come on get up' and I did and I'm glad." This showed the person's independence had been promoted.
● People told us they felt their dignity and respect were promoted. One person told us, "They always knock my door if they come in and shut it if helping me with something."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
At the last inspection in May 2018, this key question was rated as Requires Improvement. At this inspection this key question has remained at the same rating of 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;
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

- Care planning processes failed to ensure all people's care needs and preferences were gathered, met and reviewed including with regard to dementia care.
- As found at our last inspection, end of life care plans had not been completed with or for all people. This meant people's wishes and preferences had not been gathered to ensure they could be met if and when people required end of life care. This included one person for whom we saw anticipatory end of life pain relief had been prescribed.
- Timely action had not been taken to address our finding at the last inspection that people did not all have good access to activities.
- Processes failed to effectively gather information about all people's interests. For example, a questionnaire completed by staff stated one person had 'never expressed intent' about liking animals however this person could not express their needs verbally.
- Some people told us they followed their own hobbies and interests and told us they did not like the activities on offer at the home so did not join in. Staff encouraged some people to look at photographs of Birmingham from previous decades for the day's 'Good Old Days' activity. We saw some people sat with nothing to do in the lounge area, and music played at the same time as the television.
- A summer fete was held after the inspection. The manager told us money raised from this event would be used for activities. The manager also told us of possible future plans to recruit an activity coordinator to provide more personalised and one-to-one activities to people.

Failure to ensure care and treatment is appropriate, meets the needs and reflects the preferences of people using the service is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people told us they were involved in developing their care plan. One person told us, "There was a care plan. We discussed it with my family when I came here." A relative told us, "We were all involved in the care plan."
- People told us their chosen routines were respected. One person told us, "I get up when I want, go to bed when I want. I prefer it in [area of the home], I can read the paper and watch what I want."
- One person told us, "I like the company, I sit here with my friends and sometimes there are singers and my family visit. There is a fete here on Saturday." Another person was supported to move rooms to reduce the risk of social isolation.

● Relatives said they felt welcomed and able to visit people when they wanted to.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The manager showed awareness of the requirements of the above standards.
● Discussions with staff showed they knew how to interpret people's communication where people could not express their needs verbally. One person's records we sampled gave such information including their medicines records which detailed how the person would show they were in pain.

Improving care quality in response to complaints or concerns
● People were reminded of the complaints process during regular residents' meetings.
● One person told us their previous concerns had been dealt with.
● People told us they would speak to the manager if they had any concerns. A relative also commented, "I would complain to [manager] if I needed to."
● The manager had introduced a system to capture people's 'grumbles' and other feedback since our last inspection however this had not captured feedback some people shared with us during the inspection which they said they had raised with the service.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection in May 2018, this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider had failed to address numerous areas of improvement from the last inspection in May 2018 and to achieve compliance with the regulations.
- Systems did not ensure all incidents and safety concerns were identified, logged and learned from, with referrals to relevant partner agencies as required. We had made a recommendation about this at the last inspection, but this had not been followed and addressed by the provider.
- Systems failed to ensure the safety and proper upkeep of the premises and to ensure people's equipment was safely maintained. Audits had failed to identify and remove hazard and odours.
- As found at our last inspection, people's emergency evacuation plans were not readily available about people's risks in case of the event of a fire to support safe risk management. The manager was not able to produce evidence that a recent fire risk assessment had been carried out for the premises to ensure people were protected in the event of a fire. After our inspection we made a referral to the fire service due to our concerns and the provider submitted additional evidence to us.
- Since our last inspection, the manager had introduced a system to assess people's individual dependency levels however this was not used to inform staffing levels needs for the home overall to ensure there were always enough staff to provide safe care of a good quality. We received mixed feedback about this from people, as at our last inspection.
- Systems failed to ensure all people's records were accurately maintained in relation to their care and treatment. This included the lack of care planning for example for people's end of life care and dementia care to ensure all people's care needs and preferences could always be met.
- Systems failed to ensure people were supported in line with the requirements of the Mental Capacity Act 2005. People's care plans contained insufficient guidance about how to support people to make their own decisions as far as possible, and any decisions taken on their behalf. This area of improvement had been identified at the last inspection and not addressed.
- Systems to assess, monitor and improve the quality of the service and people's experiences were not always effective. Improvements were required to ensure people's survey responses and other feedback was captured and analysed, and to ensure people had regular discussions about their individual needs and preferences.

The provider had failed to establish and effectively operate systems to ensure compliance with the regulations and to assess, monitor and improve the quality and safety of the service, and the quality of

people's experiences. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had failed to ensure their own safeguarding policy was followed to help protect people and to ensure relevant partner agencies could always be notified as required about incidents and possible safeguarding matters.
● The provider's poor systems to review and monitor incidents meant the Commission and other relevant partner agencies would not be informed of all relevant incidents as required. We needed to prompt referrals and notifications to the Commission for possible safeguarding matters of bruising and a skin tear with unknown causes.

The provider had failed to take sufficient action to meet the breach identified at the last inspection with regard to their failure to notify the Commission as required. This is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are deciding our regulatory response to this breach of the regulations and will issue a supplementary report once this regulatory decision is finalised.

● As found at our last two inspections, the provider had failed to display their ratings as legally required. We prompted the provider to review their website rating display however they failed to effectively address this after our inspection.
● The provider had failed to ensure their ratings were displayed as set out in the regulations.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are deciding our regulatory response to this breach of the regulations and will issue a supplementary report once this regulatory decision is finalised.

● The registered manager left in October 2018. The assistant manager had become manager of the home but was not registered. The manager told us they had started their application in January 2019 but they had not continued this or followed up with the Commission. Our systems identified the provider was in breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to the length of time without a registered manager. We are deciding our regulatory response to this breach of the regulations and will issue a supplementary report once this regulatory decision is finalised.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Care planning processes did not gather all people's needs and preferences and identify ways to promote positive outcomes and a good quality of life as far as possible.
● People were consulted about hallway paint colours however these improvements were not timely. Discussions had started as early as February 2019 and this work had still not started.
● We received mixed feedback as to whether staff felt supported. Staff did not all feel they had sufficient guidance and leadership for their roles and to support their development.
● Relatives told us they would feel comfortable approaching the manager. One relative told us, "I find [manager] and [senior carer] approachable, I wouldn't worry about talking to them."
● A summer fete was planned shortly following our inspection which people, relatives and staff were

involved in.

● People had been asked for their views about visiting another care home with people which they responded well to. This would help people develop new relationships and allow the homes to share good practice to support possible improvements.

● Visitors, professionals and relatives described the home and staff as welcoming and friendly.

Working in partnership with others

● Healthcare professionals generally spoke positively about the service and staff. They recognised there had been recent changes to the management of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment is appropriate, meets the needs and reflects the preferences of people using the service. This is a breach of Regulation 9 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's systems did not ensure allegations or evidence of abuse were immediately investigated and to prevent abuse of people using the service. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.