Essex Partnership University NHS Foundation Trust

Rawreth Court

Inspection report

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Date of inspection visit:
05 September 2023
07 September 2023
13 September 2023
21 September 2023

Date of publication:
08 November 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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
Rawreth Court is a residential care home providing the regulated activities of accommodation, personal and nursing care to up to 35 people. The service provides support to older people living with dementia and who may also be living with mental health needs. At the time of our inspection there were 34 people using the service.

People's experience of using this service and what we found
The delivery of care for people was not always safe. Information relating to people's individual risks was not always recorded. Suitable arrangements were not in place to ensure the proper and safe use of medicines. Lessons were not learned, and improvements made when things went wrong.

Staff training was not embedded in their everyday practice. We have made a recommendation about staff training. People at risk of poor nutrition and hydration were not properly monitored to ensure their fluid intake met their needs. People were not always treated with dignity and respect. 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.

Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences. Where information was recorded this was not always accurate or up to date. The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. There was a lack of understanding of the risks and issues and the potential impact on people using the service.

Staffing levels and the deployment of staff were suitable. Recruitment practices at the service were safe. Most people and their relatives told us they or their family member were treated with care and kindness. People were supported or enabled to take part in regular social activities. People were protected by the prevention and control of infection. Staff had received an induction and formal supervision. The service worked with other organisations to ensure they delivered joined-up care and support and people had access to healthcare services when needed.

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 9 March 2019].

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 to follow up on action we told the provider top take at the last inspection.

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.

Enforcement and Recommendations
We have identified breaches in relation to consent, restrictive practices, risk, medicines management, nutrition and hydration, dignity and respect, care planning and quality assurance arrangements at this inspection. We have made a recommendation about staff training.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will also request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and Local Authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
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**

Rawreth Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
The inspection was completed by 3 inspectors, one of whom was a specialist pharmacist 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.

Service and service type
Rawreth Court 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. Rawreth Court 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 a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 5 September 2023 and ended on 21 September 2023. We visited the location's service on 5, 7 and 21 September 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority and professionals who work with the service. We used the information the provider sent us in the provider information return (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 who use the service and 7 relatives about their experience of Rawreth Court. We spoke with the registered manager and 7 members of staff, including nursing and care staff. We also spoke with an activities coordinator, a physiotherapist, the operational service manager and Clinical Lead for Compliance. We reviewed a range of records. This included 13 people's care records and people's medication administration records. We looked at 4 staff files in relation to recruitment, training, and supervision. A variety of records relating to the management of the service, quality assurance information and policies and procedures were viewed.

Requires Improvement

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. The rating for this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection to the service in November 2018, risks to people were not assessed and improvements were required to the service's management of medicines. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of Regulation 12.

Using medicines safely; Learning lessons when things go wrong
• The provider did not ensure the proper and safe use of medicines at the service. We found 11 people had missed some of their medicines between 23 August 2023 and 7 September 2023, as these were either not available or out of stock. Staff failed to identify when people were running out of their medicines in a timely manner. Therefore, suitable arrangements were not in place to ensure people had an adequate supply of all of their medicines.
• Staff did not wash their hands before and after administering a person's medicines or using hand sanitiser. Staff were observed to administer an incorrect asthma inhaler for 1 person and use the correct inhaler technique. The latter resulted in the person not getting all of their metered dose of medicine. Staff mixed 2 people's crushed medicines together. We could not be assured these medicines remained active and effective when mixed together. Staff's practice for the administration of medicines was poor and not in line with the National Institute for Health and Care Excellence [NICE] guidelines. NICE guidelines are evidence-based recommendations for care and health professionals.
• Where people were prescribed insulin, their Medication Administration Record [MAR] was not updated to reflect the correct dose of insulin to be administered in line with the specialist healthcare professional's instructions. No information was recorded to demonstrate if people received an extra dose of insulin when their blood sugar readings were above safe levels. We could not be assured if people received this medicine as the prescriber intended.
• We observed not all medicines were stored securely to ensure these were not accessible to those not authorised to have access. We found medicine trolleys were not always locked and there was a potential risk of thickening powder being easily accessible to others.
• Where people were prescribed PRN [when required] medicines, protocols were not routinely in place. A PRN protocol provides information about what the medicine is for, symptoms to look out for and when to offer the medicine.
• There were no individual risk assessments in place for people taking medicines that can cause bleeding and bruising or fire safety risk assessments for people prescribed paraffin-based creams. People's care plans contained little or no information about how staff should support them with their medicines. There was no specific detail about diabetes or covert medicines management for staff to follow and this placed people at risk of harm.

Significant improvements were required to the management or medicines as the current arrangements were not safe. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Assessing risk, safety monitoring and management
• The provider did not ensure safe moving and handling techniques were adopted and followed by staff. We observed 2 separate incidents whereby staff assisted people to move in a way that was unsafe and placed them at risk of harm.
• Not all risks to people's safety and wellbeing were identified, assessed, and recorded. Where risks were recorded there was not enough detail as to how the risks posed should be mitigated. There was no information detailing the specific nature of the risk, the impact on the person using the service and the steps required by staff to mitigate this to keep people, others, and staff safe. For example, where people's care records referred to them being at risk of exhibiting behaviours that could be distressing to themselves and others. No risk assessment was completed detailing the risks posed and the steps required to keep people safe.
• Personal Emergency Evacuation Plans [PEEPs] documented the level of staff assistance necessary to evacuate safely. These failed to identify the equipment required, people's physical and neurological needs which would affect their ability to evacuate, their ability to communicate and understand instructions and where they could be anxious and distressed.

Arrangements were not robust to manage and mitigate risk for people using the service. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Appropriate fire detection, warning systems and firefighting equipment were in place and checked to ensure they remained effective for people's safety.
• Hot water outlets were tested at regular intervals to ensure the water emitted remained safe and within recommended guidelines. An analysis for legionella had been carried out and this confirmed no bacteria was detected. This ensured environmental risks were safe for people using the service.

Systems and processes to safeguard people from the risk of abuse
• People and their relatives considered themselves and their family member to be safe living at Rawreth Court. A person told us, "I do feel safe here, because people are around me". Relatives told us, "I came to look at Rawreth Court and wanted to cry because it was so different from where [family member] had been previously. Therefore, I feel they are 100% safe here", "If I had any doubt of [family member] being safe, they would not be here" and, "[Family member] is completely safe here."
• Staff had received safeguarding training, were able to tell us about the different types of abuse and describe what actions they would take to protect people from harm and improper treatment.

At our last inspection to the service in November 2018, staffing levels were not always being maintained to meet peoples needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider no longer remained in breach of this regulation.

Staffing and recruitment
• People and relatives told us there were enough staff at Rawreth Court. However, some people told us staff were too busy to chat with them. No concerns were raised by people's relatives about staffing levels at the service.
• Our observations during the inspection demonstrated there were enough staff on duty at all times to meet

people's needs. For example, staff were present within communal lounge areas and call alarms were answered promptly.
• Staff recruitment records demonstrated relevant checks were completed before a new member of staff started working at the service. This included an application form, written references, proof of identification and Disclosure and Barring Service [DBS] checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
• We were assured the provider was preventing visitors from catching and spreading infections and promoting safety through the layout and hygiene practices of the premises. Relatives told us their family member's bedroom was always clean and tidy.
• We were assured the provider was supporting people living at the service to minimise the spread of infection.
• We were assured the provider was using PPE effectively and safely. Staff confirmed there were always sufficient supplies of PPE readily available.
• We were assured the provider was making sure infection outbreaks can be effectively prevented or managed. We were assured the provider was responding effectively to risks and signs of infection.
• We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
• Relatives were able to visit their family member without any restrictions imposed and in line with current government guidance. We observed a steady flow of visitors to Rawreth Court throughout each day of inspection.

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 inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection to the service in November 2018, staff were not effectively applying the principles of the Mental Capacity Act 2005. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of Regulation 11.

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.

• The provider was not acting in accordance with the requirements of the Mental Capacity Act 2005. We identified signs of a 'closed culture' whereby blanket restrictions were imposed and were not the least restrictive option.
• All bathroom and toilet doors were locked. No people using the service could access these facilities without being accompanied by a member of staff. The registered manager confirmed this was to keep people safe, particularly those who were at risk of falls. Although initial action was taken by the registered manager to unlock the doors, these were relocked by staff. A further discussion had to be held between us and the registered manager to reverse this practice. No information was recorded to demonstrate people using the service or their relatives had given their consent for this arrangement or that this decision was in their best interest.
• At our last inspection to Rawreth Court in November 2018, we found people's bedrooms doors were

alarmed and when opened emitted a loud high-pitched sound. We were advised this was used to alert staff when a person's door was opened. At this inspection, this remained the same. No information was recorded to verify people using the service or those acting on their behalf had given their consent to this arrangement or that this was in their best interest. The above restriction remained imposed without an assessment of people's needs having been considered or completed.
• Not all people's DoLS were submitted in time to the Local Authority. The provider had not made a reapplication to the Local Authority to renew the application before it expired. Following the inspection, the provider confirmed an application had been resubmitted to the Local Authority.

Suitable arrangements were not in place to gain consent from people using the service or those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005. This demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills, and experience
• Observations of staff training did not provide assurance staff were skilled and competent to effectively apply their learning in their day-to-day practice. Not all staff were able to demonstrate an understanding of good dementia or person-centred care to meet the needs of people using the service.
• Some staff had been given the role of 'champion' in key subject areas. The role of a champion is to promote, identify and signpost their colleagues to 'good practice' initiatives and to act as a good role model. None of these staff had attained a higher level of training in these key areas. This meant we could not be assured staff were suitably qualified and competent to lead on these key roles and to effectively support their colleagues in line with good practice procedures and legislation.

We recommend the provider seek national guidance to ensure training is embedded in staffs day-to-day practice, interventions and interactions with people using the service.

• Newly employed staff had received an induction. Staff had completed the 'Care Certificate' as part of their induction. The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life.
• Staff received regular formal supervision. Staff told us they felt supported and valued by the registered manager.

Supporting people to eat and drink enough to maintain a balanced diet
• The dining experience for people was not as positive as it could be to meet people's needs.
• People were not always given a choice of drinks and snacks. Staff did not ensure fluids were freely available throughout the day, as well as with meals. We observed 1 person have a request for a drink outside of the mid-morning drinks round refused by a member of staff.
• Staff did not always use pictures or show the food on offer to present the meal choice in an understandable way. People were not always told what food they were eating.
• Staff did not ensure people's hydration levels were maintained in line with their assessed needs. No information was recorded to demonstrate how this was being monitored and addressed to mitigate their risk of dehydration.
• A member of staff was observed to outpace and rush 1 person whilst assisting them to eat. The member of staff did not allow enough time for the person to chew and swallow their food. Although there was no impact for the person using the service, this placed them at potential risk of coughing and/or choking.

Improvements were needed to ensure the dining experience for people was positive and that people's nutritional and hydration needs were being met and monitored. This was a breach of Regulation 14 of the

Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Where people were at risk of poor nutrition, their weight was monitored and appropriate healthcare professionals, such as dietician and Speech and Language Therapy Team [SALT] were consulted for advice and support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Suitable arrangements were in place to assess people's needs prior to their admission. People's protected characteristics under the Equalities Act 2010, such as age, disability, religion, and ethnicity were identified as part of a person's need assessment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Relatives told us they were kept up to date about their family members needs and the outcome of health-related appointments. A relative told us the service contacted the GP surgery when their family member developed a cough. They told us, "I always get a call if anything is not right." Other comments included, "If [family member] is not well, there is always a call to let me know" and, "I am always updated on [family member's] health."
• The service worked with other healthcare organisations to ensure they delivered joined-up care and support; records suggested people had access to healthcare services when needed.

Adapting service, design, decoration to meet people's needs
• Rawreth Court is a purpose-built care home. People had personalised rooms which supported their individual needs and preferences.
• There were adequate dining and communal lounge areas for people to use and choose from within the service. The service was decorated and furnished to a good standard.
• People had access to an outside space and private spaces were scattered throughout the service to enable people to spend time with their families, visitors, or to have time alone.

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 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
• Care was not always delivered in a way which respected the person being supported or maintained their dignity.
• The provider and staff did not always understand the importance of privacy and dignity for people using the service. For example, on the first day of inspection, all people using the service were given green plastic cutlery to use to eat their lunchtime meal. All people using the service drank from plastic beakers and were given the same choice of drink. No consideration was given to treat people as individuals, to support their self-respect/esteem or promote a person-centred culture. A person using the service found the above insulting and told us, "Night staff bring me a drink with a lid on it to suck from, but I am not a baby."
• Where people required staff assistance to eat, this was not always provided in a respectful and dignified manner. On the first and second day of inspection, several members of staff were observed to stand up whilst supporting people to eat, rather than being seated at the person's eye level.

People were not always treated with respect and dignity. This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
• Not all people using the service stated they liked living at Rawreth Court. Comments included, "The staff are okay, but I don't really like it here", "It's alright living here. Some staff are caring, but others have old fashioned ideas of care. I think it [Rawreth Court] has gone downhill a bit" and, "I would sooner be at home, but staff are kind to me."
• Relatives were very complimentary regarding the care and support provided for their family member. Comments included, "I have never really left [family member] before but because I feel so confident with their care, I am taking a holiday. I know they are in good hands", "The staff are always very kind to me and to my family member. I would spot it straight away if they were not happy here" and, "[Family member] came to Rawreth Court from hospital, so I did not know what to expect. I have been very pleased. They are always clean and tidy. The staff are very friendly and helpful."

Supporting people to express their views and be involved in making decisions about their care
• People and those acting on their behalf had been given the opportunity to provide feedback about the service through the completion of a satisfaction questionnaire.
• People and those acting on their behalf had been given the opportunity to attend family meetings. A relative told us, "I am invited to regular family meetings."

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 inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant people's needs were not always met.

At our last inspection to the service in November 2018, care plans did not fully reflect peoples holistic care and support needs or provide sufficient guidance for staff as to how these were to be met. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of Regulation 9.

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

- People did not have a plan of care detailing all of their care and support needs and how this was to be delivered by staff. Not all care plans were reflective of people's current care needs. This meant there was a risk that relevant information was not captured for use by care staff to demonstrate appropriate care was being provided and delivered in line with people's support needs.
- Care plans provided no information relating to people's dementia and mental healthcare needs, and the impact this had on their overall health and wellbeing. No positive interventions or coping strategies were recorded to guide staff on the support required to ensure people's needs could be met. This meant there was a risk staff did not have access to all information needed to provide personalised care that was safe and effective.
- Where people could be anxious and distressed, individual care plans did not have personalised information needed to guide staff on how to intervene effectively through de-escalation techniques or other agreed good practice approaches.
- No information was recorded to demonstrate people using the service and their relatives were actively involved in developing their care plan.
- Where people were judged to be at the end of their life, there was a lack of detail recorded relating to their decisions about their preferences for end-of-life care.

Care plans were not in place for all people using the service and people did not receive person-centred care that met their needs. This demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager informed us they would support people with end-of-life care and work with health care professionals such as the palliative care team, people and families to support good end of life care.

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.

• We did not see enough evidence of how the Accessible Information Standard [AIS] had been applied. The activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.
• Not all care plans had communication records in place to guide staff on how best to communicate with the people they supported.

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
• Staff ensured people living at Rawreth Court were able to maintain positive relationships with others who mattered to them, for example, family members and friends.
• Staff responsible for facilitating social activities at the service demonstrated enthusiasm and commitment to their role.
• People were observed to participate in group activities and to receive one to one support. Relatives told us there had recently been a 'games day' whereby different games had been set up in various rooms for people to try. Special events were recognised, for example, the King's Coronation and the women's football world cup. During the inspection staff were observed to sit with people and to look at books, magazines and to do colouring.

Improving care quality in response to complaints or concerns
• The service had a complaints procedure in place for people to use if they had a concern or were not happy with the service.
• Relatives were confident that any concerns or complaints would be listened to, taken seriously, and acted upon. Comments included, "I have no complaints, I would go to the manager if I needed to" and, "I am sure the manager would address any concerns, I haven't needed to raise any issues."

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.

At our last inspection to the service in November 2018, quality assurance and governance arrangements were not reliable or effective in identifying shortfalls in the service. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of Regulation 17.

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

- The provider's quality assurance and governance arrangements were not reliable or effective to identify where the service was compliant with regulations and to identify shortfalls, including non-compliance with regulatory requirements. Lessons had not been learned to drive improvement. The lack of effective oversight and governance of the service at both provider and service level, has resulted in several continued breaches of regulation.
- Suitable audit and governance arrangements were not in place to monitor the service's medicine practices and procedures. Medicines were not effectively audited as these had not identified shortfalls as detailed in the 'Safe' section of this report. The provider's lack of oversight failed to ensure appropriate and prompt actions were taken to address staff's poor medicines practice.
- Effective oversight and governance arrangements were not in place to ensure each person using the service had an accurate and complete record in place, including a record of the care and treatment to be provided and delivered by staff. Risks to people's safety were not identified and recorded, including how the risks were to be mitigated for people's safety.
- We identified signs of a closed culture at Rawreth Court, whereby restrictive practices and approaches to care were in place as detailed in the 'Effective' section of this report. This identified the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005. This had not been addressed following our previous inspection of the service in 2018.
- The provider was reporting accidents, incidents and safeguarding concerns to the Care Quality Commission as an NHS Trust. However, as the service is registered as an adult social care service, we did not have access to this data. This demonstrated the provider and staff did not understand the different operating systems between secondary care, for example, hospitals and adult social care. Following the inspection, the registered manager retrospectively submitted statutory notifications from 1 April 2023 to us as requested.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The registered manager told us they received good support from the operations service manager and received regular formal supervision. However, the registered manager did not feel supported by the organisation.
• Senior staff were not available to provide support and guidance to staff to enable them to effectively carry out their roles and responsibilities. Staff did not recognise their responsibility and accountability to identify and question poor practice with colleagues. The provider had failed to recognise the importance of this role.

Arrangements were not in place to make sure effective systems and processes were in place to assess and monitor the service to ensure compliance with regulatory requirements. This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection the provider forwarded an action plan to the Care Quality Commission, detailing how they intended to address the shortfalls identified during the inspection.
• Relatives were complimentary about the registered manager. Comments included, "The manager is very approachable", "The manager is very approachable if I need to speak with them" and, "The manager is very good, you can always talk to them" and, "The manager is great."
• Staff confirmed they enjoyed working at Rawreth Court and found the registered manager amicable. Comments included, "[Registered Manager] creates a lovely atmosphere at Rawreth Court", "I love it here, I think I will be working at Rawreth Court for a long time" and," The best thing I like about working here, is I feel welcomed and part of a team. The manager gives good support."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Suitable arrangements were in place for gathering relatives' views about the quality of service provided.
• Staff meetings were held regularly to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service.
• Regardless of the concerns identified during the inspection, relatives and staff spoken with told us they believed the service was well managed and led. Relatives confirmed they were happy with the care and support provided for their family member. Comments included, "I think all of the staff are very good and caring. They [staff] always communicate with us and are just wonderful", "[Relative] gets good care. My [other relative] is in another care home. This care home is far better than where they are" and, "The care [relative] receives is very good."

Working in partnership with others
• Information demonstrated the service worked with others, for example, the Local Authority, healthcare professionals and services to support care provision. However, there was no evidence to show that the local Dementia Intensive Support Team or Community Mental Health Team, who provide support to people living with dementia and/or mental health care needs were involved at the service. This is uncommon based on most people living at Rawreth Court having a formal diagnosis of dementia or were living with a mental health condition. Following the inspection, the provider told us they collaboratively worked with the above agencies as required.

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 Care plans were not in place for all people using the service and people did not always receive person-centred care that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place to gain consent from people using the service or those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Improvements were needed to ensure the dining experience was positive and people's nutritional and hydration needs were met and monitored.

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 Significant improvements were required to the management of medicines as the current arrangements were not safe. Arrangements were not robust to manage and mitigate risks for people using the service.

The enforcement action we took:

Issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Arrangements were not in place to make sure effective systems and processes were in place to assess and monitor the service to ensure compliance with regulatory requirements.

The enforcement action we took:

Issued a Warning Notice