Quality Homes (Midlands) Limited

Oaks Court House

Inspection report

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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
Oaks Court House is a residential care home providing personal care to 28 people aged 65 and over at the time of the inspection. Some of the people at Oaks Court were living with dementia. The service can support up to 41 people.

People's experience of using this service and what we found
People were not always safe as the infection prevention and control procedures were not effectively implemented. The provider did not have effective systems in place to identify environmental issues which could put people at the risk of harm. The physical environment did not support the needs of people living with dementia or those with sensory needs.

People were not always treated in a respectful or dignified way. People were not always provided with information in a way they could understand. The provider did not have effective systems in place to identify and drive good and safe care provision.

People received their medicines as prescribed. Staff understood how to protect people from the risk of abuse and knew what to do if they suspected something was wrong. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice

People were protected from the risks abuse as the staff team had been trained to recognise potential signs of abuse and understood what to do to if they suspected wrongdoing. The provider had assessed the risks associated with people's personal care. Staff members were knowledgeable about these risks and knew what to do to minimise the potential for harm to people.

People received safe support with their medicines by staff members who had been trained and assessed as competent. The provider had systems in place to complete an investigation, should a medicine error occur, to ensure the person was safe and lessons were learnt to minimise the risk of reoccurrence.

The provider supported staff through training and one-to-one supervision. People were supported to have enough to eat and drink and maintain wellbeing. People were referred to additional healthcare professionals when required.

The provider had systems in place to encourage and respond to feedback from people or those close to them. The provider and management team had good links with the local communities within which people lived. The provider had made appropriate notifications to the CQC when required.
The provider, and management team, had good links with the local communities within which people lived.

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

Rating at last inspection
The last rating for this service was requires improvement (published 30 September 2020). The service remains rated requires improvement. This service has been rated requires improvement or inadequate for the last four consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
The inspection was prompted in part due to concerns received about keeping people safe. A decision was made for us to inspect and examine those risks

We have found evidence the provider needs to make improvements in all the key questions we inspected.

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

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.

We found evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections of this report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oaks Court House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe, treating people with dignity and how the service was managed.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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

Oaks Court House

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.

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
Day one of this inspection was completed by two inspectors 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. Day two was completed by one inspector.

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

At the time of the inspection Oaks Court House did not have a manager registered with the Care Quality Commission. However, they had recently appointed a manager who had started their role and was in the process of applying to become a registered manager. This means they will, along with the provider, be legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Day one of this inspection was unannounced. However, we gave the service notice of the inspection on our arrival in the carpark. This was because we had to gather information on the home's current COVID 19 status and the providers procedures for visiting professionals. Day two of the inspection was announced.

What we did before the inspection
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 asked the local authority and Healthwatch for any information they had which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and two relatives. We spoke with seven staff members including three carers, the manager, domestic support, cook and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spent time in the communal area with people to help us better understand their experience of care.

We looked at the care and support plans for four people and looked at several documents relating to the monitoring of the location including training, medicines, health and safety checks. We confirmed the safe recruitment of two staff members.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included further conversations with the manager and nominated individual and review of a service improvement plan developed after our inspection site visit.

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 the last inspection this key question was rated as requires improvement. At this inspection 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.

Assessing risk, safety monitoring and management

● People were not safely supported whilst at Oaks Court House. The physical environment was unsafe and in places poorly maintained. For example, we saw the provider had failed to identify or rectify potential trip hazards presenting a risk of injury. Hot water system pipes were exposed in communal areas presenting a risk of burns. Additionally, we saw potentially hazardous items were left in areas where people living with dementia accessed presenting a risk of injury from accidental ingestion. This included cleaning products in an unlocked cupboard in the dining room and toiletries left in communal bathrooms. We saw lose wires under bathroom equipment and wires hanging from the conservatory roof within easy reach of people entering this area. These issues put people at risk of harm.

● The provider had failed to ensure potentially hazardous areas of the home were secure. For example, on several occasions on day one we saw the door into the kitchen was propped open from the communal dining area. We saw people living with dementia freely walking into and out of this area on multiple occasions without staff members being present. This put people at risk of injury from hot or sharp objects. The staff room was unlocked and on entering we found cleaning products and ant killer. This area was accessible to people living with dementia. We took action at the time of the inspection to identify our concerns and had potentially harmful products removed and the areas locked.

● The provider failed to identify or mitigate unsafe staff behaviour. For example, we saw staff members boiling water in an electric kettle in an area easily accessed by people living with dementia. We asked a staff member about this and they said, "I know what you are saying people may get burnt, but this is how it's always been." We asked the kitchen staff about this who said it was where the plug is but then removed it to a safer place in the kitchen. This lack of oversite and awareness of potential harm put people at risk of scalds or burns.

Preventing and controlling infection

● The provider failed to ensure the physical environment was effective in preventing the spread of infectious and communicable illnesses. For example, we saw dining and quite room chairs which were visible engrained with dirt, fabric chairs where the cloth had ripped exposing the foam below, tables and chairs where the varnish had perished exposing bare wood and handles in communal toilets were heavily rusted. These prevented effective infection prevention and control practice putting people at risk of contracting illnesses.

● The provider failed to ensure staff members had they guidance and support to effectively follow infection prevention and control practices. For example, we asked one staff member how often high frequency touch points, light switched and door handles, were cleaned. They told us they usually got around to this once a day. On the morning of day one we identified what appeared to be organic matter on one light switch. In the

afternoon of day two this same organic matter was still on the same light switch meaning this had not been cleaned and anyone touching this would be at risk of a contractible illness. We found similar dirt on other lighting. On day one we identified, what a staff member later described as, faecal matter on the leg of a raiser chair in a communal toilet. We saw this was still there over four hours later. Multiple people had used this area and no staff member or manager had taken action to identify or remedy this until we pointed it out.

● In other areas of the home we saw a soiled mattress stored in a communal bathroom, dirt and dead insects on communal equipment, dirty garden furniture where people sat, over chair tables fixed with what appeared to be a medical plaster, cardboard packaging still left on people's mobility equipment and dirty stand aid equipment. These issues hindered effective cleaning putting people at risk of harm.
● The provider failed to ensure the kitchen area was kept clean and suitable for the preparation of food. For example, we saw heavily rusted equipment, engrained dirt on other pieces of equipment, food items left out and uncovered and the door and insect screen propped open allowing pests unhindered access to the food preparation area. We saw care staff habitually entering this kitchen area without appropriate protective clothing and people living at Oaks Court House walking in and out of the area without protective equipment on.
● We asked to see the providers Legionnaires' risk assessment and any subsequent action plan. Legionnaires' disease is a potentially fatal form of pneumonia caused by the inhalation of small droplets of contaminated water containing Legionella. The provider had not made provision for such an assessment. Neither the manager or the nominated individual understood the need for a formal risk assessment or subsequent action to protect people from contracting the illness. They did, however, have negative legionella test results from 2020 but no assessment of risk or any remedial action.

● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed. This was because staff had not received the latest training and the physical environment was not maintained to a standard where effective practice could be achieved.
● We were not assured the provider's infection prevention and control policy was up to date. Following this inspection, we had to direct the manager and nominated individual where to access the latest guidance.
● We were not assured the provider was using PPE effectively and safely. The manager and staff told us they had not received the latest training on how to safely use PPE equipment.
● We were somewhat assured that the provider was meeting shielding and social distancing rules. However, Oaks Court House supported people living with dementia and maintaining a safe distance was not always possible.

Following this inspection we forwarded our concerns with the local authorities environmental health department for their consideration.

We found no evidence that people had been harmed however, systems were not robust enough to ensure safe care and treatment. This placed people at risk of harm. These issues constitute a breach of Regulation 12: Safe Care and Treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed they had started to address our concerns including the commencement of a deep clean and the commission of a legionella risk assessment.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

People were supported to identify and mitigate risks associated with their care and support.
● The provider assessed risks to people and supported them to lead the lives they wanted whilst keeping the risk of harm to a minimum.
● We saw assessments of risks associated with people's care had been completed. These included risks related to skin integrity, malnutrition and mobility.
● Staff members knew the risks associated with people's care and support and knew how to keep people safe whilst providing assistance.

Staffing and recruitment
● People were supported by enough staff who were available to safely care for them. Staff were available for people promptly and had time to spend with them in an unhurried and valuing way.
● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with others.

Using medicines safely
● People's medicines were managed safely, and people received their medicines when they needed them.
● The provider had systems in place to effectively and safely respond should an error occur.
● People who took medicines only when they needed them, such as pain relief, were supported by staff who had information available. This gave staff instructions on the administration of this medicine, including the time between doses and the maximum to be taken in a 24-hour period.

Learning lessons when things go wrong
● The provider had systems in place to review any reported incidents, accidents or near misses. For example, they reviewed any falls or incidents to see if anything could be done differently in the future to keep people safe.
Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse and ill treatment as staff members had received training on how to recognise and respond to concerns.
●Information was available to people, staff and visitors on how to report any concerns.
● The provider understood how and when to make a referral to the local authority if they were concerned about a person.

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, when this key question was looked at, it was rated requires improvements. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider failed to ensure the care and treatment of people was only provided with the consent of the relevant person. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11. However, other improvements were still required.

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

- The physical environment did not support people to fully meet their needs. For example, we saw people living with dementia, and those with sensory needs accessed, communal areas and corridors. However, we saw these areas were poorly maintained and dimly lit. Several light fittings were not working in the main corridor between the lounge, dining area and communal toilets. Two out of the three lights in the conservatory were not working. This meant people were not able to fully orientate themselves independently in these areas at differing times of day. Doors to individual rooms and communal facilities were poorly and inconsistently identified meaning people's ability to independently move around the home was hindered.
- The outside communal area was poorly maintained and did not encourage people to access this space. For example, we saw two shopping trollies, a broken commode, broken gazebo frame and a small filing cabinet left in this area. One day two of this inspection we did see some of these items had been removed and the provider was in the process of jet washing the paving slabs.

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

- People's physical, mental health and social needs had been holistically assessed in line with recognised best practice. People told us they were involved in these assessments and they reflected their individual needs.
- People were supported by staff who knew them well and how they wished to be assisted.
- People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessment. Staff members could tell us about people's individual characteristics and knew how to best support them. This included, but was not limited to, people's religious beliefs and personal preferences.

Staff support: induction, training, skills and experience

- People were assisted by an appropriately trained staff team. Staff told us they completed an induction which included practical training like moving and handling and safeguarding. New staff also worked

alongside other more experienced staff members until they felt confident to support people.
● Staff members told us they received regular support and supervision sessions. These were individual sessions where they could discuss aspects of their work and training.
● Staff members new to care were supported to achieve the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to have enough to eat and drink to maintain a healthy lifestyle. The provider and staff worked alongside other healthcare professionals to ensure people's dietary needs were met.
● People were referred for specialist assessment, regarding their eating and swallowing, when it was needed. Staff members were knowledgeable about any recommendations and consistently supported people in a way which met their needs.

Staff working with other agencies to provide consistent, effective, timely care
● Staff members had effective, and efficient, communication systems in place. Any changes in people's needs were relayed to the management team who sought appropriate advice and guidance from healthcare professionals. For example, we saw one person's mobility needs had recently changed. The manager sought advice from a healthcare professional and their mobility care plan changed to reflect the latest advice.
● Staff members could tell us about the needs and medical advice of those they supported. This means staff were up to date and worked in a consistent way with people to ensure their needs are effectively met.

Supporting people to live healthier lives, access healthcare services and support
● People had access to additional healthcare professionals including dentists, GP's and Physiotherapists.
● Staff members we spoke with were knowledgeable about people's healthcare needs and knew how to support them in the best way to meet their personal health outcomes which included, but was not limited to oral health.

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 provider had made appropriate applications in line with the MCA and the provider had systems in place to ensure any expired applications were reapplied for in a timely way to ensure people's rights were maintained.
● We saw people were encouraged to make decisions where they could. For example, we saw people being offered different activities and lunch options.

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, when this key question was looked at, it was rated requires improvements. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At our last inspection we identified people were not always respected. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

Ensuring people are well treated and supported; respecting equality and diversity. Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect. For example, we saw one communal toilet where the toilet seat was missing. People were expected to sit on bare porcelain if they used this toilet. Additionally, we found none of the three main communal toilets had toilet paper and neither did several of the communal bathrooms on the other floors. We spoke with the management team about this and they replaced the toilet paper. However, on day two we still saw several communal bathrooms without toilet paper. The manager told us a staff member must have taken it out to use in someone's room. However, this did not display a respectful or dignified approach towards people.
- In several communal toilets and bathrooms, we saw a lack of hand drying facilities. For example, paper hand towels were missing. We asked the manager about this and we saw on day two paper hand towels had been provided. However, some of these were placed on top of the dispensers and still in their protected packaging preventing people from effectively accessing and using them.
- People were expected to use facilities which were visible dirty, and which did not convey a valuing and respectful experience. For example, we saw tablecloths, where people ate their meals, were dirty and stained and place mats were coming apart.
- People did not have information personal to them kept confidential. For example, during day one of this inspection we found an unlocked room containing peoples individual medical and financial records. Details of these records could also be clearly seen through the glass on the door. We raised this with the manager and again on day two we found this door was still unlocked. However, this was locked later that day.

We found no evidence that people had been harmed however, people were not always respected or treated in a dignified way. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We did see some kind and respectful interactions between people and staff. We saw people sharing jokes with staff members and engaging in conversations about topics they had in common. One person said,

"Nothing is too much trouble for them. The staff are all lovely."

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

● People said they were supported to make choices and decisions about the care and support they received. For example, we saw one person could not decide what they wanted for lunch. They were provided with a couple of options and ultimately chose a small portion of each. We saw other examples where people were supported to make decisions about medicines, activities and contact with families.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection when this key question was looked at it was rated requires improvements. At this inspection this key question has remained the same. This meant people's needs were not always met.

At our last inspection people did not receive care which was person-centred. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9. However, other improvements were still required.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People did not have the information they needed or presented in a way they could access. For example, we saw several people ask staff members what was for lunch. The staff member did not know and there was no information available for them to look at. There was a board in the dining room outlining what was for breakfast, but a staff member told us this never changed.
- There was an information board in the communal corridor with prompts to inform people what staff were on duty, the weather, activities and what was for lunch. However, this was not filled in throughout day one but had been completed on day two of this inspection. This meant people did not have access to information to help inform their day.

Improving care quality in response to complaints or concerns

- We saw information was available to people and relatives on how to raise a concern or pass on a compliment.
- We saw the provider looked at complaints to see if anything could be done differently and where needed apologise. However, we saw several complaints had been received regarding the care of people's clothing. On entering the laundry area, we identified a large pile of clothes was left on the floor. The manager could not tell us if these clothes were still in use or not. Regardless, personal items, such as clothing, should be treated with care and respect which indicated the provider failed to make positive changes as a result from complaints.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People and, when needed, relatives were involved in the development and review of their own care and support plans. These plans gave the staff information on how people wanted to be assisted. One person said, "I've still got my independence and I can still do some things for myself."
- Staff members knew those they supported. Staff could tell us about people's lives so far including likes

and dislikes, interests, personal and family history, health needs and preferences.
● People's care and support plans were reviewed to account for any personal or health changes. These plans also reflected advice and guidance from visiting healthcare professionals.

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
● People were encouraged and supported to develop and maintain relationships with those that matter to them, both within the service and the wider community. One relative told us they found the visiting arrangements easy and felt supported to keep in contact with their family member during the pandemic.
● People took part in activities they found interesting. One person told us they took part in games and crafts. Another person said, "I like my sewing and knitting. I know it's old fashioned but it's what I like, and I've got it with me in the living room. People enjoy themselves here."

End of life care and support
● People and relatives were supported to identify any end of life wishes including advance decisions regarding treatment and preferred place of death. Where people had made arrangements, this was known by the staff members supporting them.

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 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.

At our last inspection we identified the provider's poor governance did not ensure a continuous improvement in the quality and safety of care people received. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- The provider did not have effective quality controls systems in place. For example, daily checks completed by the manager failed to identify the issues we found at this inspection. This included, but was not limited to, dirty equipment, fixtures and chairs. They failed to identify or address hazardous substances left out in communal areas or poor cleaning practices. They failed to ensure people were treated with dignity and respect or correct any unsafe staff members practice. For example, they failed to ensure the kitchen remained secure preventing people living with dementia from entering unsupervised.
- The nominated individual completed checks regarding the physical environment yet failed to identify potential risks resulting from raised pathing slabs, lose wires under bathroom equipment or conservatory ceiling, they failed to identify or correct poor infection prevention and control practices or to implement an effective service improvement plan. The latest "Provider Audit" completed by the nominated individual stated the home was clean and tidy and there was no bare hot water pipework in the building. They failed to identify the exposed radiator pipework in the communal areas of the home or the issues we identified regarding the cleanliness of the home.
- The provider had introduced a maintenance log but none of the issues we found with the home's environment were identified in this log. For example, missing lighting in the corridors or conservatory had not been identified for repair or replacement.
- The management team had failed to effectively implement previous service improvements plans provided following previous inspections. For example, following our last inspection the provider told us they would implement a full maintenance programme to cover all the home facilities, both internally and externally. However, at this inspection we saw many issues with the physical environment both internally and externally which put people at the risk of harm. This included, but was not limited, to supermarket trollies and broken commode in the garden area.
- The provider had failed to demonstrate continued and sustained improvements. This was the fourth consecutive inspection where breaches in regulation have been identified. At this inspection we have

identified breaches in safety, how people are treated along with the providers quality assessment systems.
● Additionally, this was the third consecutive inspection where the provider has been in breach of regulation regarding their quality monitoring processes.
● Oaks Court House did not have a registered manager at the time of this inspection. However, they did have a manager who was in the process of registering with the CQC.

Continuous learning and improving care
● The management team did not demonstrate they had kept themselves up to date which changes in health and social care. For example, we asked the manager about the latest personal protective equipment donning and doffing procedure. They told us they were not aware of this and did not know this training was available. The nominated individual was not aware of where to access the latest government guidance on infection prevention and control. Neither the manager nor the nominated individual knew their responsibilities in relation to the prevention of legionella.

We found no evidence people had been harmed however, managerial oversite was not robust enough to demonstrate their quality monitoring was effective. These issues constitute a continuing breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and provider had appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The management team sought the feedback from people, relatives and staff on the care provided and where necessary made changes to improve the experience of care for people.
● People, relatives and staff members said the management team was approachable and they felt supported by them.

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 was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were involved in decisions about where they lived including what to do and what to eat.
● Staff members found the management team approachable and supportive.

Working in partnership with others
● The management team had established and maintained good links with the local communities within which people lived. For example, GP, social work teams and physiotherapists.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity or respect.

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 The environment was not safely maintained. Some staff practice was unsafe and the providers infection prevention and control practice was ineffective.

The enforcement action we took:

We have imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers quality monitoring systems were inadequate to identify or drive good care.

The enforcement action we took:

We have imposed a condition on the providers registration.