Oldbury Grange Nursing Home Ltd

Oldbury Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Oldbury Grange is a nursing home, which provides care for up to 89 people over two floors in three units. Anker House on the ground floor provides mostly residential accommodation for people, some who are living with early on-set dementia. Hayes House on the first floor provides nursing care and Remember Me is a unit for people with more advanced dementia care needs. At the time of our inspection visit there were 88 people living at Oldbury Grange.

People's experience of using this service and what we found
There were not always enough staff on duty to keep people safe and meet their needs and requests. Staff understood the importance of risk management. However, records to support risk management were not always consistently completed. Systems and processes were ineffective in managing and responding to safeguarding concerns. Incidents were not always reported to CQC when required.

Although some improvements had been sustained since our previous inspection visit, some areas had deteriorated. At the time of the COVID-19 pandemic, the provider's infection prevention and control measures were not effective, so people were not consistently protected from the risks of cross infection. Risk management in relation to the premises was ineffective.

Since our last inspection, staff had not continued to receive updated training and guidance to ensure they could meet people's support needs. People were not effectively supported to maintain their nutrition and hydration needs and access the health care they needed. The culture and practices of the service did not support people to have maximum choice and control of their lives.

People's privacy and dignity was not always respected. The provider did not ensure that people's care plans were up to date. Staff worked with the same people regularly, so they knew them well. People could engage in some group activities, however, not everyone had enough to do to stimulate and interest them. The environment required improvement to ensure people felt respected and cared for and to help them orientate to their surroundings.

Some staff were seen to be thoughtful and kind, spoke to people with friendliness and humour and took time to acknowledge and encourage people. When people had made decisions about their end of life care, this was documented in their care plan.

The provider had appointed a new manager since our last inspection visit. The new manager was supported by a deputy nurse manager, an operations manager, a facilities and finance manager and the provider. However, immediately following our inspection visit, the new manager and operations manager left their roles. We found the roles of the management team at Oldbury Grange were not clearly defined, to ensure ownership of their responsibilities. Quality assurance procedures were ineffective in ensuring actions were consistently taken to improve the service.

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 23 November 2018) and there was a breach of regulation 12 safe care and treatment. The provider completed a monthly action plan after the last inspection to show what they would do and by when to improve. At this inspection the provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: safe care and treatment. We also identified breaches in Regulation 18: staffing, Regulation 17: good governance, a breach of the Regulations 2009, Registration Requirements, Part 4, 12(2) Statement of purpose and a breach of the Regulations 2009, Registration Requirements, Part 4, 18(1) Notification of other Incidents. The service has deteriorated to Inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about infection control procedures and the safety of the premises. We also needed to follow up on action we told the provider to 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
We have cancelled the provider's registration.

Follow up
The overall rating for this service following the inspection was 'Inadequate' and the service was therefore in 'special measures'. This meant we kept the service under review.

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**

Oldbury Grange Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by two inspectors, a specialist nurse advisor 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
Oldbury Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the CQC. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first and second day of our inspection was announced. We gave the provider an hour's notice of our inspection visit on the first day of our visit. This was to check that procedures were in place for visitors entering Oldbury Grange, and there were no current cases of COVID-19, before crossing the threshold. We visited the service on the second day by arrangement with the provider. On the last day of our inspection visit we arrived at the service unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We looked at information shared with us by the Warwickshire Fire and Rescue Service. We sought feedback from local authorities who work with the service, and who were regularly visiting the service at the time of our inspection visit. This information helps support our inspections. We used all of this information to plan our inspection.

The provider had not recently been asked to complete a provider information return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report

During the inspection
To gain people's views and experiences of the service, we spoke with three people who lived at Oldbury Grange and thirteen people's relatives. We observed the care and support provided and the interaction between people and staff.

We spoke with the provider, the nominated individual who was also the operations manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. In addition, we spoke with the maintenance officer, the finance and maintenance manager, the acting manager (referred to as the manager in this report) and the administrator. We also spoke with two nurses, the deputy nurse manager, a care supervisor, a team leader, two members of domestic staff and five members of care staff.

We reviewed a range of records. This included eleven people's care records, including care plans, risk assessments, charts of the daily care they received and wound management records. We reviewed 23 medicine records, two staff personnel files, including recruitment records and the provider's quality audits and checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 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.

Assessing risk, safety monitoring and management;
At our last inspection, the provider had failed to robustly assess and mitigate risks relating to the health, safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment). At this inspection the provider was still in breach of regulation 12. Ineffective risk management continued to be a concern.

- Some relatives did not feel confident risks to their family member were managed effectively. One relative commented, "I think [name] is safe. I do think they [staff] could be a bit more responsive as [name] had a couple of falls recently. I don't always feel that I get the information that I should."
- Actions to reduce the risk of skin damage to people were not consistently undertaken. For example, some people needed to be repositioned regularly as they were at high risk of developing pressure sores or had developed pressure sores. Records did not always evidence that people were repositioned in accordance with their care plans, placing them at increased risk of skin damage.
- Where people were at risk if they did not drink enough, care plans instructed staff on how much fluid people needed to maintain their health. However, records showed people at risk of dehydration were not being consistently offered the amount of fluid they needed. Despite assurances from the manager that people would be offered more drinks, on the third day of our inspection we found no action had been taken to ensure people were always offered enough fluid to maintain their daily fluid requirements.
- We were not assured staff understood how to care for people with diabetes. One person's care plan informed staff to offer them a sugar free diet. However, their nutritional risk assessment informed staff to offer the person biscuits and Weetabix and tea with sugar. This posed a risk of staff following an incorrect care plan and providing food that could be harmful to the person's health.
- The provider did not ensure environmental safety risks were mitigated. A fire inspection undertaken by the Warwickshire Fire and Rescue Service in April 2021 found gaps in fire safety standards. When we inspected, we found actions still needed to be undertaken to ensure the environment met fire safety standards. For example, we found the route to a fire exit was significantly narrowed by a medicine cupboard, three pressure mattresses and a linen trolley.

Preventing and controlling infection;
- The provider's infection prevention (IPC) and control measures continued to be ineffective. This was a concern specifically during the COVID-19 pandemic.
- Staff frequently wore face masks below their nose which did not offer effective protection against the risk of spreading COVID-19. One relative told us, "They [staff] have all the PPE, but they don't always wear it."
- Not all visitors were routinely asked to provide evidence of a negative Lateral Flow Device test result for COVID-19 before entering Oldbury Grange.

● We were not assured outbreaks could be effectively prevented. Measures to ensure the environment was kept clean and monitored for cleanliness and hygiene were ineffective.
● Not all the toilets and bathrooms were equipped with soap or paper towels to ensure that good hand hygiene was maintained by staff, visitors and people.
This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. We raised our IPC concerns with the provider and asked them to give us their assurances some immediate action would be taken to improve people's safety.

Staffing and recruitment
● At our previous inspection the provider was confident staffing levels were adequate because they had introduced a system to assess this. At this inspection we found the provider had failed to maintain their systems to assess staffing levels. The number of care staff identified by their dependency tool was not always maintained. Staffing levels impacted on the safety and quality of care people received and systems to assess staffing levels were inadequate.
● Comments from people included; "I don't think there are enough staff. I worry all the time about people falling. I often have to keep an eye on [person] because they try to get up." Another person said, "Sometimes I don't call for help because there isn't enough staff. Sometimes I have to wait two hours."
● Staff specifically shared concerns about the number of clinical staff on duty. Comments included, "Nurses usually work long days 7.30am to 9.30pm (14 hours) to provide cover and they also work across two units" and, "Nurses are overstretched so they leave." The provider told us nurses did not always work a 14hour shift, and sometimes only worked for seven hours at a time.
● During a mealtime we observed two incidents where a person had to intervene to support another person who was at high risk of falling. No member of staff was available to respond to the risk of the person falling.
● We found one member of staff struggling to support 11 people on the Remember Me unit, many of whom wanted to walk with purpose. People walked around the corridors and appeared disorientated. No staff were available to orientate or offer them comfort and distraction.
● There were no cleaners scheduled to work after 2.30pm. A lack of cleaning staff meant that there were increased demands on the staff team in the afternoon and evening to maintain cleanliness and hygiene.
This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

Systems and processes to safeguard people from the risk of abuse
● Staff were trained in safeguarding. However, we were not assured staff and managers would report safeguarding concerns appropriately. Staff and managers told us they were worried about being honest and open with inspectors, as they feared they would lose their jobs if they spoke up.
● We found important events and incidents involving people had not always been reported to CQC or the local authority safeguarding team as required.

Using medicines safely
● At this inspection improvements had been made to the management of medicines.
● However, we found that nine people were prescribed Zopiclone which is a drug commonly used to help people sleep. This had been prescribed as 'take one at night' but the medicine administration record [MAR] told staff to give the medicine at 6.00pm. This placed people at risk of falls because those people who may have liked to stay up later were given a medicine that would make them sleepy. On the third day of our inspection the administration time of these medicines had been changed to later in the evening.

Learning lessons when things go wrong
● The provider did not always learn from errors or shortfalls in care practices and standards. The provider

had failed to make sustained and embedded improvements to their service following CQC inspections.
● A recent IPC audit carried out by the local authority identified the environment did not meet the approved standards expected. Remedial actions had not always been taken to remedy the shortfall.
● The provider failed to maintain accurate records of falls and injuries at Oldbury Grange, so that a review and analysis of these events could take place and lessons could be learnt.

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 this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● The advice of health professionals was not always followed to maintain people's health and wellbeing. One person who was at risk of low fluid intake was assessed by a dietician. The dietician had recommended the person have at least 1500mls of fluid each day. Records showed the person was not being offered this amount of fluid each day.

● The provider had not ensured that the mealtime experience offered socialisation and stimulation to encourage people to eat and drink more. During the three days of our inspection visit we saw the main dining room was not used for mealtimes.

● One person told us that because there were not enough staff, food was sometimes served cold. They said, "[staff] will give someone a spoonful, then move on to someone else, when they go back the food is cold."

● Mealtimes were set to a routine determined by the provider which did not give everyone enough space in between meals to build up an appetite. One person said, "I don't really eat much because it's too early. Dinner is at 5:30pm and lunch is at 1:00pm, we don't get a choice."

● When people did not finish their food, alternatives were not offered.

● Two relatives told us their relative had lost weight. One commented, "[Name] has lost weight. I know they [staff] were supplementing [name] with drinks." However, the lack of choice and encouragement at mealtimes were missed opportunities to encourage people at risk nutritionally to eat and drink.

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

● The environment did not provide visual stimulation or contrast in colours to meet the needs of people living with dementia. There was limited signage to help orientate people and it was difficult to tell where corridors led.

● There were limited objects of interest that could spark curiosity and stimulation or provide opportunity for staff to have meaningful engagement with people. When there were items that could be used to offer stimulation and enjoyment these were sometimes broken.

Staff support: induction, training, skills and experience

● Some staff supported people with needs that caused them to experience distress during caring interventions. However, not all staff received training to be able to respond to these situations safely and consistently.

● The provider's training records showed there were ten members of night-time care staff who had not received refresher training in safeguarding. Night-time staff had also missed training in dementia care, fluid and nutrition, how to put on and take off PPE, and mental capacity. When we brought this to the attention of the manager we were told this training would be arranged for night staff.

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

- People were not always being supported by external health professionals such as the district nursing team. This meant there was a lack of external oversight by visiting healthcare professionals to share guidance and good practice. At the end of our inspection regular attendance from the district nursing team had been arranged by the provider.

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

- People's capacity to make their own decisions, was assessed and where relevant DoLS applications had been made to the legal authority.
- Where people lacked the capacity to make all of their own decisions, we were not assured people were supported to make decisions about their care and welfare 'in their best interests'. For example, some people were being given medicine to help them sleep at 6.00pm in the evening. People who were at risk of poor nutrition were not supported to have meals at times that suited them, to encourage their nutritional intake.

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 this key question was rated as Good. At this inspection this key question has now deteriorated 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; respecting equality and diversity;
● The provider did not ensure management and staff culture with regard to respecting people's rights to, dignity and privacy recognised when care standards fell short. We found inappropriate and undignified signage relating to one person's continence care on their bathroom door which was visible to people who walked past.
● The provider had a list of which people to shower or bath on certain days. This task-based approach to care failed to recognise the importance of supporting people to make choices.
● The language in one person's behaviour support plan was unsuitable and guided staff to tell this person that their behaviour was 'unacceptable' rather than acknowledging their support needs.
● One person was supported with their personal care by two members of staff. The person's body was uncovered below the waist and visible to anyone who passed their room as there were no curtains or blinds on their windows which looked out on the corridor. We raised this with the manager and on the second day of our inspection blinds had been put up.
● The language used by staff to describe people's needs was undignified and lacked a person-centred approach to care. One staff member referred to people who required assistance to eat as "feeds".
● Not everyone was supported to wear clean clothes and footwear. One person on the unit for people living with dementia had dirty slippers and trousers and the staff member supporting this person had not identified this.
● Staff did not treat the environment with respect or recognise that it was the home of people who lived at Oldbury Grange. Dirty mugs and half eaten food was left on windowsills and in various areas of the home, all of which was accessible to people.

We found this was a breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 10, Dignity and Respect.

Ensuring people are well treated and supported;
● We observed some kind and caring interactions between some staff and people who lived at the home. People and their relatives told us they felt some staff were caring. Comments included; "The staff are very friendly and [name] laughs and jokes with them'', "[Name] has such a strong mental attitude that if it wasn't for the staff [name] would not be as strong", "The senior nurses are very caring. They spend time talking to the patients [people living at the home] and there is a nice interaction. The atmosphere is very jolly and happy.''

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

● People were not always given a choice of when they wanted to eat their meals, as meals were delivered at set times according to the provider's schedule.

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 this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- Relatives told us they were not routinely involved in planning their relative's care. One relative said, "Definitely do not feel involved with [name's] care planning. I don't get any communication [from managers]."
- Care records were not always kept up to date to reflect people's current needs and preferences. For example, an emotional support care plan for one person described them as being very settled recently. However, this conflicted with what staff told us about this person and what we witnessed on the first day of our inspection visit, where the person displayed distress and agitation.

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 carer's.

- There was a lack of accessible communication tools being utilised for people with learning disabilities and who were living with dementia. There was a lack of signs and information to help people understand their environment.
- Care records were stored electronically and people were allowed access to their records on request. However, there was no information available about how to request information in accessible or alternative formats, or if these would be made available. We raised this with the manager who was unable to demonstrate how people were informed about requesting accessible information.
- The provider has not always ensured people's individual communication needs were met. One person became very anxious and distressed during personal care and we were told this was because of the masks staff were wearing. Although we were told staff could wear clear masks, we could not locate any at the PPE stations around Oldbury Grange and staff continued to wear masks which they knew were a barrier to communicating with this person.

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

- Activities were planned on a daily basis, however, according to activity schedules only one activity was planned at a time to meet the needs of 87 people. We witnessed some people take part in a group activity during which they appeared engaged and enjoying the activity. However, less than 20 people were in the communal lounge to benefit from this engagement.
- There were not enough activities to ensure every person was supported to live a life that provided

meaningful engagement and stimulation to prevent boredom and promote healthy mental well-being. People and their relatives told us they would like more to do. One relative said, "I pay so much towards [name's] care and think they could do a bit more. They [name] sit in a chair all day and they [staff] could do more with activities so [name] had something to focus on.'' Another relative told us, "They [staff] seem to get [name] out of bed and put [name] in a chair, and that is it.'' One relative told us the amount of activities had declined. They said, "When [name] went there three years ago there was a lot of music played and exercise which they responded to. Even pre-COVID those activities seem to have declined...without activities I worry about mental decline.''

● Each day of our inspection the sun was shining. We noticed no-one was outside enjoying the weather. The manager told us, "It's a shame, we didn't know it was going to be nice weather today, we have kept to our plan to be inside." This indicated there was no flexibility for people, or opportunities to be responsive to people's individual preferences. In addition, the garden was not set up with tables, chairs and shaded areas to encourage people to use the space available.

● Some relatives told us about how visiting restrictions, due to the COVID-19 pandemic had impacted on their ability to visit as often as they wished. The provider told us that visiting had been restricted due to COVID-19 and the extra procedures required to ensure people entered the home safely.

Improving care quality in response to complaints or concerns

● People and relatives told us they knew how to make a complaint using Oldbury Grange's complaint policy, if they needed to.

● We reviewed the provider's complaint log. This showed no complaints were received in 2021. However, one relative told us they had made a complaint about their relative not receiving a second COVID-19 vaccination in 2021. This complaint and the provider's response had not been recorded on the complaints log. We could therefore not be assured the provider was learning from complaints or concerns.

End of life care and support

● Some people told us they had been involved in planning care and support, that met their preferences, at the end of their life. However, people were not consistently supported to have plans in place at the end of their life which involved them and their relatives. One family member told us, "I have tried on a couple of occasions to have a meeting with the manager to discuss end of life arrangements. That discussion has still not happened.''

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.

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

● There was a new manager in post at the time of our inspection visit. The manager had not been working at Oldbury Grange for more than five weeks, and therefore had not been able to complete a registration process with CQC to become the registered manager. The manager was supported by a deputy nurse manager and an operations manager. However, immediately following our inspection visit the manager left their employment. In addition, the operations manager left their employment. The provider responded by appointing a new manager and an independent consultant to support the service.

● The provider and operations manager understood their responsibilities and the requirements of registration. For example, the operations manager knew what notifications were required and when these should be submitted to CQC. However, we found CQC had not always been notified of wounds/injuries to people. A lack of communication at the service between clinical staff and managers meant that senior managers were not informed of incidents where notifications were required.

We found this was a breach in the Health and Social Care Act 2008, (Registration) Regulations 2009, Registration Requirements, Part 4, 18(1) Notification of other Incidents.

● The provider had failed to update their statement of purpose when changes took place at Oldbury Grange. Changes included changes of managers and staff, and a change of provision of available services they could offer to people.

We found this was a breach in the Health and Social Care Act 2008, (Registration) Regulations 2009, Registration Requirements, Part 4, 12(2) Statement of purpose.

● Managers were not always clear about their roles, and the roles of others at Oldbury Grange. For example, there was confusion over who was responsible for environmental maintenance. In addition, there was confusion about who was responsible for the clinical oversight of people's care, especially if people did not reside on the nursing unit.

● Governance systems and processes to ensure that the provider continually assessed, monitored and mitigated risks to the health, safety and welfare of people failed.

● Environmental risks including infection control and fire safety were not managed effectively or safely.

● Systems to ensure safe staffing levels were ineffective and a lack of managerial oversight of known risks to people's health and safety, meant risks were not adequately monitored or mitigated.

● Care records were not always kept up to date. Management told us this was due to a poor connection which meant hand-held electronic devices linked to care records did not always work. We raised this with

the provider, when we visited on the third day the provider had purchased a number of new hand-held devices. However, staff said this issue had previously been raised with the provider and had not been rectified. Care staff continued to share the new hand-held devices. This meant information regarding people's current health and care needs was not always accessible to staff and they were unable to maintain accurate records of the care people received.
● Previous improvements had not been sustained. For example, procedures to monitor effective wound management had not been maintained.
● Following our inspection in October 2018 we imposed a condition on the provider's registration to provide us with a monthly summary of their improvement actions and an analysis of their monthly audits. The provider had supplied us with this information. However, actions described to us as being undertaken, were not effectively and consistently completed.
This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider understood their responsibility to inform people and families, CQC and other agencies when incidents occurred within the service. However, they did not always do so.
● We received mixed feedback from people, their relatives and staff about whether the service was managed in a way that was open and inclusive.
● People and their relatives told us that communication could be improved. Relatives told us, "The communication and information to me could be better'', ''I know they have a new manager. I emailed him a few weeks ago to ask if possible, to have a meeting...I have not had any response yet'', and "I don't think the communication I get is very good. I know they [staff] are busy, but they are meant to inform me each week about [names'] condition and they don't.''
● Systems to gather feedback from people and their relatives were inconsistent. Some people and their relatives described being asked for their feedback and a recent residents meeting showed people were asked for their opinion. However, other relative told us they could not remember being contacted to ask for their views. One relative said, "I have not been approached at any time to see whether I think the service is good, and I have not received feedback forms about the service.''
● Staff and managers told us they were worried about being honest and open with inspectors, and speaking up. One staff member told us they were disappointed about the attitude of one manager who made personal comments about their appearance.
● Staff had begun attending team meetings once again, which gave them the opportunity to discuss any issues and ideas for improvement. The operations manager explained during the COVID-19 pandemic some meetings had not routinely occurred, and some staff supervisions were not up to date. Plans were in place for staff to have more regular meetings and supervision opportunities.

Working in partnership with others
● There had been a lack of engagement with other health professionals since our previous inspection visit. The provider told us they had struggled to get district nursing teams to visit Oldbury Grange, to treat people with their health conditions. However, following our inspection visit the provider reported district nursing teams were now visiting regularly.
● The previous registered manager had established multi-disciplinary meetings on a unit basis and attended by a senior manager, the nurse, the unit care co-ordinator and a member of care staff. The focus of the meetings was to discuss each person's needs and identify actions that could be taken to improve people's outcomes. However, these meetings had ceased and opportunities were lost to continue with this

collaborative approach to problem solving; which did not help to promote accountability and improve standards of care at Oldbury Grange.

● The provider and management team were not responsive when external agencies highlighted areas in need of improvement. They did not take immediate action to address concerns.

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 Treatment of disease, disorder or injury	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider had failed to keep their statement of purpose up to date.

The enforcement action we took:

The provider's registration has been cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of notifiable events, including serious injuries to service users.

The enforcement action we took:

The provider's registration has been cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity were not respected

The enforcement action we took:

The provider's registration has been cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk management was not effective

The enforcement action we took:

The provider's registration has been cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to assess,

Treatment of disease, disorder or injury	monitor and improve the quality and safety of the service were not operated effectively.

The enforcement action we took:

The provider's registration has been cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of quality and skilled staff available to provide effective and safe care to people.

The enforcement action we took:

The provider's registration has been cancelled.