Pepperhall Limited

Valley Court

Inspection report

Valley Road
Cradley Heath
West Midlands
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15 February 2022

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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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Valley Court is a nursing home providing personal and nursing care to up to 69 people. The service provides support to older adults and people living with dementia. At the time of our inspection there were 53 people using the service. The home accommodates people on two floors. One floor specialises in the care of people with dementia and nursing care needs. The lounges and dining areas for people on both floors are situated on the ground floor.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Many people and relatives did not know a new manager was in post as the change had been very recent. The manager had plans to ensure everyone was aware of the recent changes. We found systems and processes to ensure people's safety and quality of care were not sufficient.
We found planning to support staff in an emergency was not sufficient. We saw some areas of carpet were causing a trip hazard. These issues were addressed by the manager and staff during the inspection. People and their relatives told us they felt safe. One relative told us; "I have no concerns at all, I know [my relative] is safe."
We saw activities were limited for people living on the first floor. Staff had not always completed their refresher training. The manager assured us they were addressing both of these concerns. People and relatives told us they enjoyed the food and we saw that people had plenty of choice. One relative said: "The food is fantastic."
We found that systems were not robust which meant that not everyone received good care. However people told us staff were kind and caring. One relative said; "The staff talk to us like family because [all the people living here] are treated like family."
We found that people on the upstairs floor had not been consulted or their needs fully considered when their lounge and dining area were excluded from their use. The manager was taking steps to rectify this during our inspection. Relatives told us they felt confident to speak to staff about any concerns and they would be addressed.

People were not always supported to have maximum choice and control of their lives. Staff did not always 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.

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 6 February 2021).
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. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
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. This included checking the provider was meeting COVID-19 vaccination requirements.

The inspection was prompted in part due to concerns received about health and safety issues in the home, the choice people had about daily activities and the quality of care plans. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider continued to need to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. During the inspection the manager and staff were already addressing the concerns raised and took steps to address concerns we found during the inspection.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, safety of the environment and systems and processes to ensure safe and good quality care at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Valley 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 included checking the provider was meeting COVID-19 vaccination requirements. 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 carried out by two inspectors, an assistant inspector and Nurse specialist advisor.

Service and service type
Valley 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 and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. 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
This inspection was unannounced.
Inspection activity started on 10 February 2022 and ended on 18 February 2022. We visited the location on 10 February 2022 and 15 February 2022.

What we did before inspection
The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and

improvements they plan to make. Please see the well led section of this report for further details.
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 all this information to plan our inspection.

During the inspection
During our visits to Valley Court, we spoke with seven people living at the home, 15 members of staff including the home manager, quality manager, nurses, care team leads, care staff, kitchen and domestic staff. We spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider. We looked at a variety of documents including six care files, multiple medication records, staff recruitment files, various risk assessments, staff training records, quality assurance checks and audits and policies and procedures.
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
After the site visits, we spoke with six relatives about the care their loved ones received and 12 staff including nurses and care staff. We sought additional information and documentation regarding infection prevention control checks and procedures, quality assurance checks, a variety of risk assessments, care file evidence and further policies and procedures.

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. At this inspection the rating has remained requires improvement. 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

- Two people who had moved into the home most recently did not have personal emergency evacuation plans (PEEPS) in place. This meant in the event of an emergency, staff would not have any guidance to help support those people appropriately in the event of an emergency such as a fire.
- We found there was no emergency response kit in place to support people and staff in the event of a fire. This meant in an emergency staff wouldn't have been able to provide all the information the emergency services might need. This could slow down response times and endanger people's lives.

Systems to protect people in the event of an emergency were not sufficient and people were at risk of harm. This was a breach of regulation 12 (2) (a) (b) (c) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager and staff took immediate action to address these concerns. PEEPS for the two people identified were produced on the day of our first visit. An emergency kit had been prepared shortly after this.

- The carpet on the first floor was worn and had become wrinkled. This posed a trip hazard to people and staff. The home manager was in the process of arranging replacement flooring and work had commenced by the end of the inspection.
- A new system for recording and monitoring falls had been introduced. However, we found on some occasions two members of staff had recorded the same fall which was causing some confusion. We raised this with the home manager who took immediate action to ensure staff knew only one of them must record a fall. We also noted that a fall which had happened the night before our visit had not yet been recorded fully, this was completed during our visit.
- We saw there had been recent work to improve the monitoring and recording of the fluids people were drinking. The home manager had updated staff guidance on fluid monitoring having liaised with the GP. Staff we spoke with were aware of these updates and how and when to escalate any concerns.

Staffing and recruitment

- During our visits we saw staff spent time talking with people and the atmosphere was relaxed. However, staff had mixed views about staffing levels at the home. Some felt that staffing levels were adequate, some felt recent reductions in staffing had sometimes left them rushing and unable to spend enough time with people. The home manager explained the rationale for the staff changes as part of a wider plan to improve how staff work and support people. On the days of inspection there were enough staff to safely meet people's needs. We did not see any impact on people's safety as a result of staffing levels.

● The home manager showed us a dependency tool that was being used to assess how many staff were needed at particular times of the day. The home manager felt this tool was not very effective as it made assumptions that people would all be getting up and eating at the same time. The home manager explained they were looking for a tool which reflected people's individual choices about when to get up and when to eat.
● Staff files showed that the service had completed Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who understood what signs could indicate abuse and what action to take if they were concerned. One staff member told us; "I report any concerns to the management or a senior on shift, they would ask me to write a statement."
● People told us they felt safe living at Valley Court, one person said; "I do feel safe, if I shout or [press the call alarm] they come, if I have any worries I tell them."
● Relatives told us they felt their relatives were safe. One relative told us; "I don't have to worry at all I know [my relative] is safe."
● The manager alerted the authorities to suspected abuse and liaised with the appropriate professionals. They took action to address any concerns they found.

Using medicines safely
● People received support to take their medicines safely. We saw records recorded clearly when and how people had taken their medication.
● Staff told us they received training in medicines administration and were clear on what procedures needed to be followed. We saw checks were made to ensure staff were supporting people safely and appropriately with their medicines.
● Some people had medicines prescribed as required (PRN). There was appropriate PRN guidance for staff and medicines administered had been recorded with the reasons for use.

Preventing and controlling infection
● We were somewhat assured that the provider was accessing testing for people using the service and staff. We saw the system used to monitor whether staff had done their COVID-19 testing in line with government guidance was not effective. Records contained gaps and it wasn't clear whether a test had not been done, or the staff member wasn't on duty and didn't need to test. Staff told us they were testing in line with guidance and were knowledgeable about their responsibilities for testing.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff were able to tell us about how they had managed recent outbreaks at the service in line with guidance at the time. However, the COVID-19 risk assessment to guide staff during an outbreak had not been updated since 2020 and was not in line with government guidance. The quality manager completed an updated COVID-19 risk assessment during our inspection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

People were facilitated to receive visits from their loved ones. In the event of an outbreak essential care givers and relatives whose loved one were near the end of their lives could still visit. Some relatives told us they did not know all people living in care homes had the right to an essential care giver. We shared this with the home manager who agreed to write to all relatives to make sure they were aware.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.
The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Learning lessons when things go wrong

- There were systems in place to monitor accidents and incidents within the home. We noted that some staff recorded a fall as an incident and some as an accident. This could make monitoring of falls and falls management more difficult. The home manager shared some guidance with staff to ensure they were clear about the differences and how to respond in each case.
- The management team had recently developed a system to analyse patterns and trends in incidents and accidents. There had not been sufficient time to evidence how effective this analysis was.
- The home manager told us about a number of examples of changes which had been made in response to lessons learned. For example, blankets had been purchased following a concern where someone had been too hot with their quilt on but too cold with a cover on them.

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. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Care files included details about people's needs and preferences. However, they did not contain detailed assessment of the possible impact of removing some people's access to a lounge and dining area. Many people living on the first floor had little or no access to shared living areas. This meant they could not always choose to spend time out of their rooms, regardless of their needs or wishes. This was not in line with best practice guidance.
- At the time of our inspection the home was in the process of transferring all care files from paper to an electronic system. Staff we spoke with told us they liked the new electronic system and found it easy to find the guidance they needed about people. They also told us the system reminded them when important tasks were due or overdue.
- Where possible people's needs were assessed before admission to the service. If this was not possible, for example due to emergency admissions, assessment was done shortly after admission.
- Many of the staff had worked at Valley Court for years and knew people well. Staff told us they did look at care plans and also spoke to people about their needs.

Staff support: induction, training, skills and experience

- Staff training was mostly online. A system was used to monitor what training staff had completed. In some cases, staff had not completed mandatory refresher training, for example 79% of staff had completed updated end of life care training. This meant that some staff may not have the up to date information and skills needed to support people with end of life care. The home manager said they were working on driving improvement in this area. Staff told us they felt confident in caring for people who were close to the end of their lives.
- Relatives told us they thought staff were good at their jobs. One relative said; "They all deserve a gold medal."
- Staff told us they received an induction which helped them feel prepared for the job. One staff member told us; "The team was amazing when I was doing my induction, they answered all the questions I asked, and I felt fully confident when I started."

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

- Concerns had been raised prior to our inspection, about monitoring people's fluid intake and the widespread use of spouted cups without assessed need. We saw most people were using cups of their choice. We saw records to monitor people's fluid intake were clear and reported upon regularly.
- People told us they liked the food at Valley Court. One person told us; "The food is great." We heard a

number of people commenting on how nice the food was during lunch.
● We saw one person who did not want any of the menu options had asked for something different and they were provided with their choice.
● We saw people were offered fresh fruit and vegetables. Staff knew about people's likes and dislikes and their special dietary needs.

Adapting service, design, decoration to meet people's needs
● People's bedrooms were personalised, and they could be involved in how they wanted their room to look.
● Lounge and dining areas for people living on the ground floor were bright and comfortable. However people living on the first floor had on many cases limited access to a lounge and dining room. The lounge area was not safe for people to use and the dining area was adapted to use as a temporary staff room. During the pandemic this had often meant limited access to time spent with others and caused a risk of isolation.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last comprehensive inspection, we found that the registered provider was not ensuring that people's rights were protected, and this was a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Need for consent.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● Where people lacked capacity to make decisions about their care and treatment, best interests' decisions had been made, in line with the principles of the Mental Capacity Act 2005.
● Care files clearly documented who was subject to DoLS. Staff told us they had received training and understood what this meant for people.
● Records we checked showed that where conditions had been applied to a DoLS agreement, they had been met by the service.
● We saw staff knocking on people's doors and seeking consent before offering support.

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

- People were referred to healthcare professionals to help staff meet their health needs.
- Records showed people had access to healthcare professionals such as speech and language therapists (SALT), opticians, GP's and tissue viability nurses.

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 requires improvement. At this inspection the rating has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Although people and relatives told us staff were caring and kind, the lack of robust systems and processes failed to support an environment where people were respected and received good care.
- We noted that there was a section in the care file to describe people's sexuality and how they wished to express it. In some cases this section had not been completed. This meant staff did not always have a holistic assessment of people and could not effectively meet all of their needs. The home manager gave us assurance they planned to update this information for everyone. Care files documented people's cultural and religious needs.
- A person living at Valley Court told us; "The staff are lovely people, so friendly." Another said; "I have no complaints about this place they do look after me."
- Relatives told us they were happy with the support their loved ones received from the staff team. One relative said; "The staff are lovely." Another told us; "They are wonderful."
- We observed some good interactions between staff and people living at Valley Court. Staff spoke with people in a respectful manner.

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

- We received mixed responses from relatives about their involvement in care reviews. Some relatives told us they were consulted by telephone and others said they were not but did have a copy of the care plan.
- People had been involved in some decisions about their care. However, people living on the first floor had not been involved in the decision to discontinue the use of their lounge and dining areas.
- Review meetings were held with some people to discuss changes and improvements they would like to see in their home. People were also asked to complete surveys and we saw evidence of changes made as a result of their feedback.

Respecting and promoting people's privacy, dignity and independence

- We saw people's privacy being respected. We observed people going out independently into the community and also into the shared gardens. One person living at Valley Court told us; "They respect my privacy." Another told us they enjoyed going out to feed the birds each morning.
- Care files gave staff guidance about what people could do for themselves and what they may need help with. A person who occasionally threw their drink had been given a spouted cup. It was decided this was not dignified or needed. An unbreakable cup which looked like an ordinary mug was bought to allow the person to enjoy their drinks in a more dignified way.
- Relatives told us their loved ones were treated with dignity and respect.

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. At this inspection the rating has remained 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; 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 living on the first floor had a designated lounge and dining area on the ground floor set aside for their use. The lounge area had been filled with a large amount of furniture, most of which was not safe or suitable for people's use. This meant people were not able to choose to use their lounge. The dining area for people on the first floor had also been re-purposed as a temporary staff room. This provided separate staff rooms for the two care teams during the pandemic. This resulted in many people having to spend most of their time in their rooms. This included mealtimes. This meant that most people on the first floor had their choice to participate in group activities removed from them. The provider had failed to consider the impact of increased isolation of people's mental health. The provider had failed to fully consider alternatives for people on the first floor. There had also been a lack of monitoring of the impact on people of taking away their access to a lounge and dining area.

There was a failure to fully consider and involve people in significant changes to their care and their environment. This resulted in limitations to the choices available to them. This was a breach a Regulation 9 Person Centred Care (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager had already taken steps to address this at the time of the inspection and work was under way to clear the lounge and return the dining room to use for people.

● An activity coordinator was assigned to each of the two floors in Valley Court. The activity coordinator on the first-floor spent time in people's rooms with them. People living on the ground floor could participate in group events. We saw people singing together and playing bingo. A leaflet of planned events and pastimes was distributed.
● At weekends staff told us there was no activity or entertainment arranged for people. We spoke to the home manager about this. They advised this had already been discussed with the activity coordinators. A plan was in place to devise a weekend rota.
● Staff had good knowledge of people's needs and wishes. For example, a carer told us a person's favourite meal was breakfast. When lunchtime came, they did not want to eat the meal they had requested. A breakfast tray was brought to them with which they were very happy.

Meeting people's communication needs

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

● People had care plans in place for their communication needs. These contained guidance for staff about people's communication needs and preferences.
● Electronic care plans contained pictures and symbols to facilitate people's understanding.
● Easy read versions of the complaints policy and procedure where available for people. Surveys asking for people's feedback were also in picture format.

Improving care quality in response to complaints or concerns
● The service had a complaints policy and procedure in place. Copies of the procedure were available to people in their rooms.
● Relatives told us they knew how to raise a complaint if they needed to. They told us if they had any concerns they were dealt with quickly by the staff. One person told us; "If I notify staff of a concern they are there straight away."

End of life care and support
● Staff had completed end of life training at induction. However, some staff had not completed the online refresher training. The home manager told us they were working with the team to ensure everyone updated their training.
● Care files clearly showed when advanced decisions were in place for people.
● There were systems in place to support people appropriately when they approached the end of their lives. This included working with healthcare professionals, friends and family to make sure people's wishes were followed and the right care provided.
● During our visits there was a COVID-19 outbreak in the home, we saw family members were still encouraged to visit those who approached the end of their lives.

Requires Improvement

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 remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found that systems had not been established to monitor the risks to people's health and safety. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we found some improvements, not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● Quality monitoring systems had failed to identify carpeting on the first floor was wrinkled and was a potential trip hazard to people and staff. During our inspection the home manager arranged for work to commence on this being replaced.
● The provider had failed to ensure the risk and impact of some people not having access to a dining room and lounge were not fully considered. During our inspection the home manager had arranged for all the unsafe and unsuitable furniture to be removed from the lounge. Recliner chairs had been purchased to provide people with safe and suitable seating. Alternative arrangements were made for a separate staff area and the dining room was returned to use for people on the first floor.
● Quality assurance monitoring systems had failed to identify the business continuity plan needed updating. This meant in the event of an emergency staff would not have access to up to date guidance on how to quickly and safely respond. During our inspection a new business continuity plan was created.
● The provider had failed to ensure recommendations made to upgrade the fire alarm were actioned in a timely way. An external risk assessment was completed in October 2021. It recommended a new fire alarm system which could detect which room a fire was in. The current system could only identify the zone a fire was in which could be up to seven rooms. The replacement had been deemed 'imperative'. However action had not been taken to commence this work. During our inspection the home manager arranged another fire risk assessment and was seeking quotes to have the work completed.
● The provider had failed to identify items stored under a stairwell posed a fire hazard. During our inspection we saw several refuse bags filled with clothes, a suitcase and an upholstered armchair had been stored under the stairwell. These items were a possible fire hazard and had not been noted on daily 'walk around' checks of the home. We spoke with the home manager about this. We saw during our second visit

that the items had been removed.
● Quality monitoring systems had failed to identify some staff files did not contain evidence of identification being confirmed before staff were recruited. This placed people at possible risk from staff. The identification for the staff files we viewed was sought during the inspection. The home manager explained that they were being assisted by a human resources colleague to review all staff files.
● The provider had failed to ensure a risk assessment was in place to support the recruitment of a staff member who was under the age of 18 years. This placed people at possible risk. The home manager ensured that a risk assessment was completed during our inspection.
● Safety monitoring systems had failed to identify the monitoring of lateral flow device (LFD) testing, was not robust. Staff were asked to report their results to either the manager or another nominated staff member. The results were added to a spreadsheet. There were gaps and inaccuracies in the recording of test results. This meant people were at increased possible transmission risk as full staff testing compliance had not been assured. During our inspection the home manager created a new monitoring method. Time is needed to establish whether this new method will be effective.
● The provider had failed to identify the provider information return (PIR) had not been completed and returned to CQC. The completion of the PIR is a condition of registration. The provider stated they had believed the PIR was completed by the previous registered manager.

We found no evidence that people had been harmed and the home manager assured us they were working towards making the improvements necessary to ensure they met the requirements of this breach. However, not enough improvement had been made at this inspection and this remained a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● A duty of candour incident is where an unintended or unexpected incident occurs which results in the death of a person using the service, severe or moderate physical harm or prolonged psychosocial harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.
● The home manager understood their responsibility under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People did not always have the opportunity to be involved in how to develop and improve the service. Relatives meetings had not been held because of COVID-19 restrictions. The home manager confirmed plans were in place to hold relatives' meetings. They also advised that they planned to introduce a keyworker system. Each person would have a staff member who would be responsible for helping to ensure their needs and wishes were fully met.
● People living at Valley Court were invited to attend meetings to discuss their needs and wishes. Those who were able had been asked to complete a feedback survey. We saw people's requests had been actioned. For example people had asked for a later start to lunch and this had been implemented.

Continuous learning and improving care
● People, their relatives and staff told us they would contact the nurse in charge or the care team lead depending on which part of the home they lived in. They told us they felt confident their concerns would be listened to. Some people and relatives did not know there was a new home manager in place. The home manager explained letters had been sent out introducing them.
● The home manager and quality lead had spent time developing new monitoring systems. A number of

improvements had been planned and some were already in place. For example, staff had told them the call alarm system on the first floor can take time to check. Plans were in place to improve the way in which staff were alerted to who was calling for assistance.

Working in partnership with others

●The service worked in partnership with people's families, health and social care professionals, local authorities and faith groups to provide and improve people's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a failure to fully involve and assess the impact on people from significant changes to their home. This resulted in limitations to the choices available to them.

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 Systems to protect people in the event of an emergency were not sufficient and people were at risk of harm.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	We found no evidence that people had been harmed and the manager assured us they were working towards making the improvements necessary to ensure they met the requirements of this breach. However, not enough improvement had been made at this inspection and this remained a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

A warning notice was served. We asked the Provider for an action plan to demonstrate how the governance issues found would be addressed and monitored.