Court House (Malvern) Limited

Court House Care Home

Inspection report

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20 February 2023

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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
Court House Care Home provides personal and nursing care for up to 60 people. The home is split into 3 units; 2 were for older people and 1 for younger adults. At the time of our inspection there were 57 people living at the home.

People's experience of using this service and what we found
People's individual risks were not always comprehensively assessed to guide staff on how to keep people safe. People were not always protected from the risk of harm. An effective system was not in place for reporting and reviewing accidents, incidents and near misses involving people. People's medicines were not always safely managed, this meant people were at risk of receiving medicines which may not meet their current needs.

Care documentation was not consistently updated and some staff were not trained to meet people's specific healthcare needs. The provider did not have robust risk assessments and had failed to consistently identify environmental risks to people's safety and wellbeing.

People's person-centred needs weren't always at the forefront of their support. However, some people were supported with a range of meaningful activities and staff were attentive to people's emotional and social needs. Quality assurance systems were not always effective for people. This meant the action taken by the provider had not always ensured people received consistent, good quality and safe care. Systems were in place to seek feedback and resolve people's complaints.

The provider had not ensured all requirements under the Mental Capacity Act (MCA) and authorisations under the Deprivation of Liberty Safeguards were fully met. Not everyone was supported to have maximum choice and control of their lives and 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 always support good practice.

The provider had not always sent to us statutory notifications which is their legal responsibility to do so for notifiable incidents.

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 the service under the previous provider was good (published on 14 March 2020). This service was registered with us on 08 February 2022. This is the first inspection under this provider since their registration.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, medicines, infection control,

and management oversight of the service. A decision was made for us to inspect and examine those risks.

This service had not been inspected since a change in registration; therefore, this inspection was also carried out to gain assurances about the quality of care and systems used to monitor and manage the service under the new provider.

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 have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
Immediately following our visit, we sent the provider a letter asking them to respond to the immediate concerns we found at our visit. We continued to seek their updates and assurances they had mitigated the immediate risks to people.

We have identified breaches in relation to safe care and governance and management oversight of the service at this inspection. At this inspection we recognised that the provider had failed to submit statutory notifications to us in line with their regulatory responsibilities. Please see the action we have told the provider to take at the end of this report.

At this inspection we recognised that the provider had failed to submit statutory notifications to us in line with their regulatory responsibilities. This was a breach of regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

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.

Court House Care 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 Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 3 inspectors and a Specialist Nursing Advisor on 15 February 2023, and 2 inspectors on 20 February 2023. An Expert by Experience contacted relatives via telephone on 17 February 2023 to gather their views on the care their loved ones received. 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
Court House 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. Court House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. However, during the first day on site, we did give the provider notice we would be returning for a second day to complete our inspection.

Inspection activity started on 31 January 2023 and ended on 20 March 2023. We visited the service on 15 February 2023 and 20 February 2023.

What we did before the inspection
We reviewed information we had received about the service since they registered with CQC. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We sought feedback from the local authority and Healthwatch. 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 this information to plan our inspection.

During the inspection
We spoke to the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke to 11 staff including unit managers, nurses, senior care staff, care staff, activity coordinators, a cook and maintenance. We spoke to 8 people who live at the home, 8 relatives of people who use the service and 2 visiting professionals. We reviewed a range of care documentation, risk assessments and medicine records for people. We looked at documents around staff training and support. We reviewed a variety of records relating to the management of the service, including policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated 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.

Using medicines safely

● People did not receive their medicines safely. Medicine management practices required improvement. We found not all medicines administered had accurate medicine administration record (MAR) charts in place. This put people at risk of not receiving their medicines as prescribed.

● We found 2 people were not supported to take their Insulin as prescribed and there were several instances where they were given the wrong dose. This had the potential to put this person at significant risk of harm. The GP carried out an urgent review for people prescribed insulin to ensure they were safe.

● Where people were prescribed medicines to be dispensed via injection or transdermal patch, staff were not always rotating the site of administration. Not rotating sites could affect the absorption of the medicine and place people at risk of harm.

● Staff did not always have protocols to follow for people's 'as required' (PRN) medicines; to understand why, how and when to give the medicine and the dosage required. When PRN medicines were administered staff had not always recorded the reason why. This meant the effectiveness of the PRN medicines could not be monitored.

● Where people received covert medicines (hidden in food or drink), the provider could not be assured they were always administered safely or in line with best practice, as the pharmacist had not always been consulted on the administration method.

We found no evidence that people were harmed, however, the provider had failed to ensure that all strategies to mitigate risks had been completed and that the safe and proper management of medicines was in place. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to the concerns raised by the inspection team, the provider and registered manager took action to reduce the risk of errors with insulin administration by simplifying the MAR charts and ensuring staff had additional training where required. We will test the effectiveness of this system at our next inspection.

● Following our inspection, the provider informed us of a number of improvements they had implemented around the administration of transdermal and injectable medicines. We will review this at our next inspection.

Assessing risk, safety monitoring and management

● The provider failed to ensure risks were managed safely.

● During the inspection we identified regular checks were not fully completed to ensure the environment

was safe. This included finding some rooms that should not be accessible to people were unlocked. For example, sluice rooms, which were designed for the disposal of human waste, were not locked and cleaning cupboards were left open, which posed a health and safety risk to people.
● Where the provider had identified people were at risk of harm, they had not put in place clear guidance for staff about the action they needed to take to keep people safe. This included where people had been identified as being at risk of choking, dehydration, pressure ulcers and diabetes. For example, staff did not have guidance on how low a person's blood sugars were safely allowed to drop before emergency intervention was required.
● The provider did not ensure people who required repositioning to prevent pressure damage were being supported to do so in line with their needs. Where people were at risk of developing sore skin, they were not consistently receiving the right care and treatment. Staff told us they weren't always able to offer time sensitive support to people due to the lack of staff available to meet the needs of the people living at the home.
● Personal emergency evacuation plans did not contain correct information about the support people required to evacuate the building in an emergency. This placed people at risk of receiving inappropriate and unsafe support if the home required evacuation.
● Potential hazards that could cause harm to people were not always identified or recognised by staff. Some people had prescribed thickener (to thicken drinks). We saw this was stored insecurely in communal areas which could have been accessed by other people at the home, especially people who experienced confusion. Thickener has been subject to patient safety alerts due to the risk of choking if it is ingested and must be stored safely.

Risks to people had not always been effectively assessed and managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider told us they had introduced a new system to ensure the environment was safe for people.
● The provider has reviewed how people's repositioning charts are set up on their electronic care system, to ensure staff can accurately record the positional changes some people need to maintain their skin integrity.
● The registered manager took immediate action to remove the thickener found in communal areas and ensure all thickener was stored in a safe way.
● Following our inspection, the provider told us they had updated people's personal emergency evacuation plans and safeguards are in place to protect from any incorrect information contained in the printed plans on each unit. We will review this at our next inspection.

Staffing and recruitment
● People and their relatives told us there wasn't always adequate numbers of staff. One person said, "When we had more staff, they would take me out for a walk in the garden and it was lovely, but it hasn't happened for 6 months, now they [staff] say they are too busy." Another person told us, "I can only have one bath a week as there are only 2 staff who do the baths so there is a rota." A relative told us, "Staff numbers have been reduced in the last 6 to 8 months. I have noticed people calling out for help for a long time when I've been there."
● The provider did not use an evidence-based tool to determine staffing levels in accordance with people's needs and the environment. This meant they could not monitor when people's needs changed and be assured staffing levels remained sufficient to meet people's needs. For example, we saw staff that were working in areas of the home supporting people, were not always aware people in other areas of the home were calling for assistance due to the layout of the building.
● Staff told us their recruitment process was thorough, they had an interview and pre-employment checks

were carried out before they could start work. Staff we spoke with told us they had an induction period where they shadowed more experienced staff before supporting people on their own.
● The provider told us they used agency staff to ensure there were sufficient staff if permanent staff were not able to pick up extra shifts. There was an on-going recruitment campaign to fill vacancies.

Preventing and controlling infection
● The provider did not take sufficient action to assess the risk of, and prevent, detect and control the spread of infections. Areas in the home were cluttered with Personal Protective Equipment (PPE), Lateral Flow Test kits (LFT) and other objects, making it harder to maintain cleanliness. This placed service users at increased risk from the spread of infection.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. At the time of our inspection, the home had an outbreak of COVID-19 which had been contained to 1 unit. We observed staff working in the affected unit, then took their breaks in the staff room which was located on another unit within the home. This increased the risk of cross infection.
● We were not assured that the provider was using PPE effectively and safely. We observed staff not wearing masks or wearing these incorrectly, for example under their chin. This was contradictory to government guidance at the time of the inspection. The registered manager stated they would address this issue immediately with staff.

Infection control procedures did not consistently protect people from the risk of infection. This was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● The home was facilitating visitors in-line with government guidance. There were no restrictions on visiting the home and checks were undertaken to ensure visitors were following guidelines.

Learning lessons when things go wrong
● There was insufficient analysis of accidents, incidents and near misses to reduce the risk to people. A review of records showed incidents had not always been reported and reviewed to facilitate learning and a review of the management of risk. This meant the provider had not always learnt from previous incidents and put measures in place to mitigate the risk to people.
● In-depth analysis of falls did not take place to ensure people's wellbeing and prevent future falls. Whilst the number of falls were collated by the registered manager monthly, further analysis to identify themes and trends had not been completed.

Systems and processes to safeguard people from the risk of abuse

● The provider did not have systems in place to track and evaluate safeguarding concerns to identify any patterns or future learning. The provider did not always tell us, when safeguarding incidents occurred.
● Most people told us they felt safe living at the home. One person said, "Yes, I guess I am safe, just by being here rather than back at home".
● Staff received training on safeguarding and all staff we spoke with understood their role in identifying, reporting and recording any allegations or incidents of abuse.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Feedback we gathered from people during the inspection varied. One person said, "The food is rubbish, I get given a choice of meals the day before, but if I change my mind on the day, it's tough". Another person said, "It's the same thing every day, always roast potatoes and sprouts." A third person said, "It's okay the food".
- Staff did not always record whether people ate and drank sufficiently. For example, we found where people had catheters, their fluid intake and urine output was not always recorded consistently.
- People who required their fluid to be monitored, did not have the healthy optimum amount calculated to ensure they remained hydrated. This put people at risk of malnutrition or dehydration.
- Best practice relating to food hygiene was not always followed. We observed staff walk through the home with uncovered plates of food for people who were in their rooms. This placed people at increased risk of harm. We brought this to the attention of the registered manager and provider during the inspection and they told us they would address this immediately with their staff team.

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

- People and their relatives we spoke with told us they had not been involved in assessments or reviews of their care. This meant people were at risk of receiving inappropriate care.
- People's needs and choices had not always been fully assessed to ensure effective outcomes of their care. For example, we saw evidence 1 person's needs had recently changed. We saw no evidence the provider had identified this or updated the persons care plan to reflect the changing need.
- Assessments completed for people were basic and did not always incorporate key information. For example, we found 1 person did not have care plans in place to provide guidance for staff in relation to their medical condition or their catheter care.
- Staff we spoke with knew people well and had a good understanding of their wishes and needs.

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

- Relatives told us that they were not always contacted promptly by staff when people required medical attention, as staff might not have recognised people's deteriorating health.
- Where referrals had been made to other healthcare professionals there was not always a clear record of the advice or guidance given for staff to follow. This meant people were at risk of receiving inappropriate care.
- The provider had not effectively liaised with other agencies or professionals to ensure people's health and

care needs were met. For example, 1 person had been waiting over a year for an assessment for specialist seating. The provider had not followed up this referral or explored alternative seating provision to enable the person to leave their room safely.
● Another person had developed difficulties in communicating. The provider had failed to seek timely advice on how to address their communication needs.

Adapting service, design, decoration to meet people's needs
● Adaptations had not always been made to the environment to support those people with dementia. For example, we found there were limited signs, guidance or contrasting colours to help people orientate themselves to their surroundings.
● We found there were aspects of the provider's policies and procedures to ensure the home environment was suitably maintained were not consistently followed. For example, unlocked doors had various items stored inside including building materials which could potentially place people at risk. Following the inspection, the provider has taken action to ensure this is checked daily.
● The provider shared with us they had plans to rebuild and modernise the current buildings on the site.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Protocols for administration of covert medicines (hidden in food or drink) were not always in place to evidence MCA had been completed and best interest meetings had taken place. Following our inspection visits, the registered manager arranged for people's covert medicines protocols to be reviewed and updated.

Staff support: induction, training, skills and experience
● Relatives told us staff who regularly looked after their family members had the skills and knowledge to help them. One relative said, "Permanent staff know [person's name] well, and staff support them in the right way."
● Staff were not always competent in areas relevant to the needs of the people they supported. For example, we saw evidence staff had limited awareness of sepsis or how to administer specific medicines safely. This meant staff could not always meet people's healthcare needs.
● Staff gave us examples of training they had undertaken which was linked to the needs of the people living at the home. However, most staff we spoke with reflected they found online training less effective and would have preferred face to face training to ensure they could get the maximum benefit from the training. Following the inspection, the provider told us they are making efforts to increase staff attendance at face-to-face training sessions.
● Staff told us there was a recruitment process in place that included induction training, including

shadowing an experienced senior care staff member to build their knowledge and skills.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for, or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● People and their relatives were not always involved in the development and reviewing of their care plans. Some care plans had limited information about people and relatives' voices, wishes and feelings as part of care plan reviews. This meant that people were not always involved in directing staff and deciding how they would want their care delivered.
● A relative told us "I'm not invited to hear about [relative's] care needs". Another said, "It would be nice to be given a report rather than have to look for it".
● The registered manager had identified prior to our inspection this was an area they were working towards improving, to enable people's relatives and loved ones to be more engaged in decisions about care.

Ensuring people are well treated and supported; respecting equality and diversity
● People were not consistently provided support from staff who treated them in a respectful, kind and caring way. One person told us, "They [staff] sometimes just ignore me when they come in my room, they don't even say hello. Others [staff] will speak to each other in their own language so I'm left out of the conversation".
● People and relatives shared contrasting views about the care they received. One person told us, "They [care staff] are lovely, they try their best". A relative told us, "Communication is a big problem, most staff are caring but in a firm way".
● Staff spoke positively about their caring roles. We observed calm and caring interactions from staff towards people in communal areas.

Respecting and promoting people's privacy, dignity and independence
● Respect for people's choices in how they wanted their care was not person centred. People told us there was a rota for bathing and they had to wait until certain staff were on shift to have a bath, this usually happened once a week or fortnight. Staff told us this was because there were only 2 staff who usually supported people with this task. Therefore, they had a set rota to work to each week to ensure everyone had at least 1 bath per week.
● People told us some staff supported them to maintain their independence where possible. One person told us, "I always like to be up really early so the night staff help me get up around 6:00 to 6:30am". Another person said, "I like to stay in my room, I can please myself then".
● Staff did not always respect people's privacy and dignity. People told us staff don't always knock before entering their room. We observed some people struggling to eat their meals without assistance and staff did not offer support.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated 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

- Some people told us they were not provided with a range of meaningful activities to enhance their wellbeing or to reduce social isolation. The activity records for people cared for in their bedrooms did not show they were offered meaningful activities. One person told us, "They [management] will not tell me why I can't get out of bed, I'm stuck in the same 4 walls". Another person said, "I used to love just going out for a walk to get some fresh air but we aren't allowed now because there isn't enough staff to do it". A third person said, "We used to have entertainers coming in and singing for us a couple of times a month, we get nothing like that now. They [activities staff] try their best but they aren't given any money to pay for things".
- Feedback from people regarding activities was varied depending on which unit they resided. One relative said, "A lot of people are not making the best use of the lounge areas, it needs greater integration between residents and engaging them in social activities that are better suited to their preferences".
- Staff told us any activities carried out must be fundraised for. A member of staff said, "We held a fete last year to raise money to put towards doing things people really want to do".

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's communication needs were not always sought and reviewed by the provider. We found 1 person who been assessed by the speech and language team was provided with a communication aid. However, their care plan did not offer guidance and advice to staff on how to use this aid.
- From 1 July 2022, all registered health and social care providers must ensure that their staff receive training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. Out of 81 staff, 1 staff member had completed accessible information standard training and 45 staff had completed supporting people with a learning disability training.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and the registered manager had a system for reviewing complaints and responding to concerns.
- The registered manager told us they held a residents and relatives meeting every 3 months and sent out annual questionnaires to gather feedback on the care provided at the home. This feedback would then be

used to plan improvements.
● The provider told us the registered manager operated an open-door policy to increase engagement with people and their relatives.

End of life care and support
● When people were receiving end of life care, staff told us people were supported in a person-centred manner in line with their wishes and preferences.
● The staff team worked with health care professionals to ensure individuals were supported to be pain free.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care

- Systems and processes were not robust enough to detect the issues we found during the inspection. For example, gaps in recording food and fluid intake, conflicting information in care plans and medicine errors had not been identified.
- Audits of care plans and risk assessments had not recognised when more important information was required. For example, when to seek advice on a person's urine output, what to look for regarding sepsis and what strategies should be implemented regarding known risks.
- Systems to protect people from the risk of infection required improvement.
- Staff we spoke with shared mixed feedback regarding support they received from the provider and registered manager. One member of staff told us, "The budgets seem to have been cut since the new provider took over, staff numbers have been cut despite us saying we are struggling to give good quality care". Another member of staff stated, "We are a good staff team, we try our best to care for people, but management don't really listen to our concerns at times". A third staff member told us, "[Registered manager] is approachable, I find if I explain what impact I think the issue is having on a resident, they will listen and take onboard my concerns".
- The lack of effective quality assurance systems, processes and audits meant management and staff did not have a shared understanding of challenges, concerns and risks in relation to people's care.

The failure to implement and operate effective systems to maintain the safety and the quality of the service placed people at risk of harm. This was 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

- Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay. The provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse, authorisation of DoLS and deaths of people using the service.

The registered manager failed to complete all statutory notifications to the CQC. This was a breach of regulation 16 (Notification of death of service user) and regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Feedback from relatives was inconsistent. Some relatives told us communication with staff was very good. Other relatives told us they were not always able to contact staff quickly particularly during the evenings or at weekends.

● Some relatives gave us examples showing how staff tailored the care provided to their family members based on their family member's previous preferences, so people would achieve the best outcomes possible. However, other relatives said their family member's individual needs were not always met. For example, staff did not consistently assist their family members to spend time out of bed.

● The management team were not always visible to people living at the home. One person told us, "I don't see management that often". A relative told us, "I don't know who the manager is". In response to hearing this feedback, the provider told us the registered manager was progressing plans to be more visible within the home, including a weekly 'manager's surgery' to enable people and their relatives to book protected time with the manager.

● People, relatives and staff were asked for their feedback through meetings. We saw evidence of people and staff giving feedback on the service. However, there was limited evidence action had been taken to resolve any issues.

● The registered manager was supported by the provider. The registered manager and provider told us that they have a good working relationship, and both want to improve the service so that it can be the best.

Working in partnership with others

● Staff worked with other health and social care professionals, such as people's GPs, tissue viability and falls specialists, and social workers, to help to ensure people received the care they wanted and their needs were met.

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 provider failed to ensure risks to people relating to their care and the environment were assessed and mitigated. The provider failed to ensure the safe and proper management of medicines was in place. The provider failed to ensure infection control procedures protected people from the risk of infection.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes in place where effective in monitoring the quality and safety of the service.

The enforcement action we took:

We issued an warning notice.