Country Court Care Homes 7 OpCo Limited

# Oakview Lodge

## Inspection report

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13 June 2023

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

About the service
Oakview Lodge is a residential care home providing nursing and personal care to people. The care home accommodates 70 people in 1 adapted building. The service provides support to older people and people living with dementia. At the time of our inspection there were 69 people using the service.

People's experience of using the service and what we found.
People's care was personalised to reflect their individual needs and preferences. People's care plans did not always consistently provide enough information of identified risks or guidance for staff to safely manage them. Daily monitoring of risks to people's health were not always completed such as weekly weighing and ensuring pressure mattresses were correctly set.

Staff understood how to raise concerns and knew what to do to safeguard people. Lessons were learnt when things went wrong but further improvement was needed to ensure the outcomes of safeguarding incidents were shared. Staff reflections around clinical care required improvement to embed learning across the clinical team.

People enjoyed the meals provided; however, improvements were required to ensure the dining experience was positive. At times some people who required assistance with eating did not receive this in a timely manner.

There were sufficient numbers of staff available, however, improvements were needed around the deployment of staff, particularly during busy periods.

The quality auditing systems in place were not always effective at identifying areas for improvement. The systems had not identified the improvements identified at this inspection.

People medicines were managed safely, and people received these as the prescriber intended. Effective arrangements were in place to ensure recruitment checks on staff were safe. People were cared for in a clean, hygienic environment and systems were in place to minimise the risk of infections.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way and in their best interests; the policies and systems in the service supported this practice.

Staff provided care in a sensitive and caring manner, putting people's choices and preferences at the centre. People were supported to maintain relationships, form new friendships, and pursue their own hobbies and interests. Staff were passionate about enabling people to retain their independence and autonomy.

People and relatives felt able to raise concerns or complaints and were confident they would be listened to.

People were cared for and supported by staff who had received appropriate training.

We received positive feedback on the service and the management team. People were involved in discussions about the day to day running of the service and were kept informed of developments. The management team acknowledged when things went wrong and worked with people and partner agencies in an open and transparent manner.

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

Rating at last inspection
This service was registered with us on 02 August 2021, and this is the first inspection.

Why we inspected.
This inspection was prompted by a review of the information we held about this service.

We carried out an unannounced inspection of this service on 11 May and 13 June 2023.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment and the governance and oversight of the service at this inspection. We have also made a recommendation about staff records and ensuring that they demonstrate that staff competencies have been adequately assessed for the role they are doing.
Please see the action we have told the provider to take at the end of this report.

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

You can read the report by selecting the 'all reports' link for Oakview Lodge on our website at www.cqc.org.uk.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

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|---|---|
| **Is the service safe?**<br>The service was not always safe.<br>Details are in our safe findings below | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was caring.<br>Details are in our caring findings below. | **Good** |
| **Is the service responsive?**<br>The service was responsive.<br>Details are in our responsive findings below. | **Good** |
| **Is the service well-led?**<br>The service was not always well led.<br>Details are in our well led findings below. | **Requires Improvement** |

# Oakview Lodge

**Detailed findings**

## Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oakview Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Oakview Lodge 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 not a registered manager in post, however they had submitted their application to register with CQC.

Notice of inspection
This inspection was unannounced.

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

During the inspection We spoke with 8 people and 9 of their relatives who used the service about their experience of the care provided. Where people were unable to talk to us, we observed people's interactions with staff and the care provided to them. We spoke with the manager, the regional manager, deputy manager and 6 members of staff. We reviewed 6 people's care records and looked at the service's quality assurance arrangements.

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.

Assessing risk, safety monitoring and management

● Risk assessments needed further information for staff to understand what has been considered through the risk assessment process, what they had to monitor and how to mitigate risk effectively to keep people safe from the risk of harm. For example, risk assessments for people at risk of choking or at risk of malnutrition were in place but lacked sufficient detail. For a second person at risk of self-harm, assessments were not sufficiently detailed to guide staff how to identify when they were low in mood and how to positively support them. This meant the risk of possible harm to people was not fully mitigated as staff did not have all the information they needed to support people safely.

● Pressure relieving equipment was in place for people who were at risk of developing or had pressure ulcers. However, the mattresses were not always set to the correct setting according to people's weight. Although there was no home acquired pressure wounds, there was a risk of people developing these.

● Staff monitored the weight of people who were at risk of malnutrition and were at risk or were losing weight. We found that weights were not always recorded as needed. For example, some people were assessed needing to be weighed weekly. We found that they were not weighed in May 2023. Therefore, for some people a drop in their weight may not be picked up when needed and put people at risk of weight loss.

● Clinical practice reviews were not in place. When people caught infections like urinary tract infections or chest infections there were no analysis in place to ensure these did not occur due to incorrect staff practices or ineffective infection control procedures. For example, there were weekly clinical risk meetings. On 24 April 2023 the meeting minutes evidenced that 4 people had a urinary tract infection and 4 people had chest infections, they were treated with antibiotics. However, there was no further detail to analyse if people who had urinary tract infections had a catheter in place or not and if catheter care practice had to be reviewed. We discussed this with the manager who too immediate action.

● Care and support was not always assessed, or monitored, and actions to mitigate those risks were not always 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.

● The provider and manager assessed the risks within the environment, including building, equipment, and fire safety. There were plans to be followed in the event of an emergency evacuation. Where people lacked the mental capacity to understand risks, the staff had created additional plans to monitor them and to keep them safe. There were regular checks and services of all equipment and the building.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People told us they felt safe and that staff and would report any concerns to staff if they felt unsafe at any

time. One person said, "The staff here are wonderful and everybody is so kind, it's a nice place." Relatives gave equally positive feedback such as, "[Person's] far safer here now than at home. I've never regretted them coming in here because of what they've done.

● Staff spoken with received training to keep people safe from harm or abuse. Staff were clear about how they would report any concerns both internally to the provider and also externally to the local authority safeguarding team or CQC. One staff member said, "We report if we see anything, like an issue with skin, or not being well, or we see a bruise. We report anything that doesn't look right or is not right for that person."

● The management team understood their responsibilities to safeguard people from abuse and report any concerns when needed. When required safeguarding alerts were raised, external professionals said managers fully engaged with those enquiries positively.

● Staff were able to describe to us incidents that prompted them to share learning and improve their practise. For example, one staff member said, "We had a case where the resident had bruises. We found there were certain staff on shift, where bruises had occurred. It was investigated and discussed as a team, and we felt some staff needed more training because of the difficulties in transferring. This was done and no more bruises."

● The outcomes of internal audits such as falls in a month or weight loss were not shared as part of staff meetings. The manager acknowledged this and said they would share with staff emerging trends in the home to seek staff views on how to mitigate these risks. They acknowledged sharing and reflecting on these would further develop and embed a culture of shared learning across the staff and management team to benefit people's care.

Staffing and recruitment

● People told us staff were responsive to their needs and did not rush when providing personal care. One person said, "I particularly wanted to say how much I appreciate the night staff here, they are marvellous, just brilliant."

● We observed however that staff were constantly on the go and people were left at times to sit in their wheelchairs until staff had time to transfer them to an armchair. "Only thing I can think of that's a bit negative is I've watched sometimes in the lounge they have to wait a long time before they're taken to the toilet, sometimes they seem to have to wait for ages." We discussed this with the manager who looked at the deployment of staff at busy times and made immediate changes.

● We were told by care staff that they did not always have the time to spend with people to talk to them or carry out some extra tasks.

● Staff were safely recruited, and the provider had completed the relevant employment checks prior to them starting work.

Using medicines safely

● Medicines were administered by nursing staff. Medicine stock we checked corresponded with the electronic records. The medicine and clinical equipment storage room was clean and medicine cupboards and trolleys were locked.

● There were protocols in place for medicines people took as and when required. These were not robust and required more information as to what was the maximum dose of medicines in 24 hours staff could administer and signs and symptoms when people were in pain and could not tell staff verbally.

Preventing and controlling infection

● The service used effective infection, prevention, and control measures to keep people safe, and staff supported people to follow them. The service had good arrangements for keeping the premises clean and hygienic.

● The service prevented visitors from catching and spreading infections.

● The service followed shielding and social distancing rules.
● The service admitting people safely to the service.
● Staff used personal protective equipment (PPE) effectively and safely.
● The service tested for infection in people using the service and staff.
● The service promoted safety through the layout of the premises and staff's hygiene practices.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
● The service's infection prevention and control policy was up to date.
● The service supported visits for people living in the home in line with current guidance.
● All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food.

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 of 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● People's needs were assessed before they moved in the home. These assessments were undertaken with the person and their relatives (if appropriate) and included information about care and support needs, individual wishes and preferences. These assessments formed the basis of people's care plans and risk assessments. However, not all of these assessments were accessible on the electronic care planning system and remained in paper format. Having information in 2 different formats meant there was a risk staff may not review the information.
● Care plans were developed for each person. Some care plans needed more information and detail for staff to have all the information they needed to support and keep people safe.
● The training staff received supported them to apply their learning effectively and in line with best practice, which ultimately led to good outcomes for people's quality of life.

Staff support: induction, training, skills and experience
● Staff told us they received an induction when they first started working. They said they worked with people only when signed off as competent. Once out of their probation period staff received continual support in the form of supervision, appraisal and through recognition of good practice. Staff said they felt supported by management and said their development was well planned. One staff member said, "They supported me with training and mentorship from the manager to promote myself. I still have a long way to go, but I am doing my management training and they will continue to support me with work based assessments. We can ask for training above mandatory, so for me that is things like Parkinson's, catheter care, dementia, diabetes, sepsis."
● Staff were up to date with their basic mandatory training. Some staff had completed additional courses which were specific to people's needs. However, training provided around areas such as dementia or diabetes were basic level awareness courses. The manager said they acknowledged staff supporting people in these areas required higher level training and would organise through a local training provider who they had planned to meet after the inspection to arrange.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food provided. One person said, "The cooking here is simply marvellous I've not got beef about anything here at all." Mostly we saw staff support people to eat who required assistance. However, on the second floor we saw people were left whilst staff assisted others. One person

when staff finally assisted them refused their lunch as this was cold.
● We spoke to the manager about the deployment and timing of meals, as we saw a number of staff not helping. They told us they had identified this and during our meeting on 13 June 2023 told us they now staggered mealtimes. This meant they could ensure all people, both in the dining room and bedroom were assisted well.
● Staff did not provide people on the day with a visual choice, instead they showed picture menus and described what people were eating. This confused some people as they were unable to recall the menu option. We discussed this with the manager who told us they show people sample plates to see, taste and smell the option.
● Where people required their food to be modified, such as a soft or pureed diet, this was provided. One relative said, "Although [persons] food is puréed it's always well-presented and smells good." People's allergies were known alongside any other specific dietary requirements such as needing a diabetic diet.
● Staff recorded food and fluid intake for people. They recorded the amount people had from their meal but omitted to record what people were offered. Therefore, it was difficult to establish if people only had only 25% from their meal if they didn't like the meal. This was a missed opportunity to improve people's food intake.
● People were regularly provided with snacks, fortified milkshakes, and cakes, and we saw all people had sufficient fluid within reach. Some people had their food and fluid intake monitored. This was because they either lived with a medical condition and they had to have a controlled intake or because they were identified being at risk of malnutrition or dehydration.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
● Staff told us they involved other professionals in people's care when there was a need for it. People and their relatives told us they could freely access health care professionals such as the GP, dietician, nursing teams or occupational therapists.
● We saw a number of wounds were dressed and monitored by the in-house nursing team with very little external TVN [Tissue viability Nurse] oversight. The manager told us they had identified this and would seek to ensure TVN's had a greater oversight when needed.

Adapting service, design, decoration to meet people's needs.
● People lived in a purpose-built environment. The wide corridors and spacious bedrooms with en-suite facilities offered comfort to people. There were plenty of places people could meet, such as the bar, café, communal areas, and cinema. However, further improvement could be made to the environment to ensure more dementia friendly features were used. For example, use of contrasting colours for cutlery, crockery, tablecloths and plates to assist people living with dementia to eat independently were possible. Further improvement was also required around orientation cues in the environment to assist with people's ability to independently navigate around the home.

Ensuring consent to care and treatment in line with law and guidance The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We found the service was working within the principles of the MCA. One staff member said, "I shouldn't assume they lack capacity, I treat everyone the same until they give me cause to think maybe they don't have capacity. Even if they don't I still ask them every time if I can do what I need and respect their decision. If we need to make a decision, I leave behind my personal feelings and try to decide what is the best outcome for the person with family and doctors etc. "

● Capacity assessments and best interest decisions were completed with the person and their representative. When needed, the appropriate legal authorisations were in place to deprive a person of their liberty.

● For those people who retained capacity to make day-to-day decisions, people were encouraged to make their own decisions, while still minimising risk.

● We observed numerous examples where staff sought permission from people prior to assisting them. Staff explained what they wished to carry out, if needed explained to the person why, and if were told no, would return later to try again. People told us staff respected their wishes and only assisted or supported them with their consent.

Good

# 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 Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People and their relatives said care staff were kind, caring and treated them well. One person said, "I think they know me well enough and know my needs, the staff are good to me which is good because I depend on them for my care." A relative told us, "The staff are all lovely. They're always so welcoming, which is important, you know make you feel relaxed and happy to be here."
- Staff were seen to be attentive and responded kindly to support people's emotional needs. We saw one example where a person was clearly upset in their room. The staff member knew they were missing family and reassured them they would visit later that day. They took them to the lounge to sit with friends, and later we saw them laughing and enjoying their visit.
- Staff told us when they provided personal care they did so whilst encouraging people to be independent. One staff member said, "If I see they can still use their hands to wash their face, hair, arms and everything, I always ask them always if they can do this. Maybe put their makeup on or brush their hair, no matter where they are in their life journey, we can promote their dignity and self-respect by keeping them as independent as we can." People and their relatives confirmed staff followed this approach when providing care.
- People told us their dignity and privacy were maintained, they felt comfortable with staff providing intimate care, and said staff were sensitive when doing so. We observed most staff followed this however did observe on the second floor, some examples where this was not followed when staff discussed people. For example, a staff member was heard to be loudly discussing a person's continence needs across the dining room.

We reported this to the management team who took immediate action to address this with the staff member.

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

- People told us staff treated them as individuals and listened to their wishes and views about their care. Care records also confirmed this. For example, one care record detailed how one person wanted to eat orally and not just through a PEG [Percutaneous endoscopic gastrostomy (PEG) is a type of feeding tube]. This view was acted upon with appropriate guidance sought from nutritional professionals.
- Care workers had a thorough understanding of the people they supported. Care staff and the engagement team worked together and took their time to get to know people's individual likes, personal histories and interests formed their care plans. People looked presentable and well, groomed and staff told us how particular people liked to look with their hair, make up and fragrance etc. People who spent time in their bed were covered and had their call bells at hand to summon staff when they needed this but remained

dignified and well groomed.

Good

# 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 Good. This meant people's needs were met through good organisation and delivery.

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

● People told us they received care to meet their individual needs and preferences. One person said, "I think they know me well enough and know my needs." One relative said, "They are very responsive, and [person] gets the care they need, they know the likes and how things are done.

● The engagement team completed a life story, which captured people's history and interests. These helped care staff provide care when people became anxious or agitated about this. For example, one person refused personal care frequently. When reviewing this they saw this person would calm when particular music was played. Therefore, staff adopted this when providing personal care which then enabled staff to provide the care without refusal.

● People told us they were involved in reviewing their care, and here appropriate relatives were consulted. People told us about several examples where their care responded and supported their needs. For example, where people began to regain some of their mobility the support helped maximise independence. One relative said, "We had our own [professional] to work with [Person]. They have now trained a couple of members of staff to work, so that's really made difference to and have got them mobile again. [Person] is better here by far than in hospital, since here [person] has improved and is now asking to walk each day."

● We saw further examples were care responded to people's needs and demonstrated people's control over their care. For example, a relative told us, "[Person] has been in here about four years now and I've never regretted them coming in here because of what they've done. Like they got them off the catheter, so now less infections." This demonstrated people were empowered to make choices and have as much control and independence as possible.

● People were supported by a team who knew them well and how they liked to be supported. Although there were gaps and omissions in the care records as reported in the Safe and Well Led domain, we did not find this impeded people's care.

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 told us they could maintain relationships that matter to them, such as family and friends. One person said, "I get people visiting me any time of day and its nice." A relative said, "I can stay at night sometimes because I like to be here and they'll put bed in for me." This approach helped to protect people from social isolation and loneliness as social contact and companionship is encouraged.

● People were encouraged to engage in a range of activity, both group based, but also to pursue individual interests. People were able to continue with gardening pursuits, crafts, and music for example. One person said, "I was a musician and because I have my CD player I can still listen to my music. Those CDs, they are ones I am on and it's good for me to hear that stuff. I'm not left on my own and they always will drop in and

ask me how I'm doing. I've been here a while and like I said wanted to let you know how appreciative I am of the staff."
● People were supported to achieve their own 'Wish list.' For example, two people who were previously friends and socialised together before moving to the home wanted to spend days out together. Staff organised trips to bowling and the lunch. For a third person, staff organised horse riding sessions, which given the person was blind was particularly positive as they thought they would never have rode again.
● People were central to the wider activities in the home. People told the engagement team what they wanted to do which formed the activity planner. External entertainers regularly visited the home and numerous celebrations were held such as birthdays, Easter, and the coronation. One person said, "I do the activities quite a lot, like I love the artist who comes in and does stuff with us, that's the one lots of people really enjoy. I do the other things to like singing. I love singing and we get a singer in every now and then. We do go out and I like to have a regular walk in the garden just to get out for a while."

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

● People's communication needs were assessed, and staff had the information they needed to communicate effectively with people.
● Information was available for people in different formats.
● We observed that when people found it difficult to hear or understand, staff calmly and slowly explained themselves clearly, so people understood.

Improving care quality in response to complaints or concerns
● People and relatives told us they could raise concerns and complaints and were aware of the procedure. One relative told us, "If I wasn't happy with something they would know, but that's not the case, they are very responsive."
● The provider had a process in place for responding to complaints. Where concerns of complaints had been raised either by people using the service or those acting on their behalf these were investigated, and a copy of the outcome provided to them.

End of life care and support
● The provider had considered people's end of life wishes when completing their initial assessment. However, care plans required further development. For example, examples we saw simply recorded, "The person-centred approach will be provided to [persons] loved ones as central to the decision-making process which treats the service user as a unique individual with a unique history." There were no further explanations for staff to know what this approach meant for this person.
● Staff received training around end-of-life care and worked in partnership with other health professionals, such as the local hospice, GP and palliative care team to support people's care needs when required.

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.

- Systems and processes were in place to monitor the quality and safety of the service, but these had not been effectively operated. For example, the audits carried out by the provider or registered manager did not identify the shortfalls we found during the inspection. For example, mattress settings not set correctly, staffing deployment, or people's mealtime experience. We did not find people experienced harm but were at risk of inappropriate or unsafe care improvements as improvements were needed to minimise those risks.
- Although incidents were discussed in team meetings, further improvement was required to embed this process. For example, clinical risk meetings and clinical governance meeting minutes lacked detail. For example, in April 2023 there were 4 chest infections and 4 [Urinary tract infections] UTI's recorded. The action taken was that antibiotics were prescribed. There was no discussion around a root cause analysis, to consider if UTI's were for people who had a catheter in situ, if people with a catheter prompted a review of practice to follow good infection control.
- Incidents were recorded however, there was no formal record for how the registered manager learnt from lessons following incidents to improve the quality of care to people. We recommend the provider review their systems and processes for quality assurance to ensure more robust oversight of the service. Accidents and injuries analysis from April 2023 had been completed. This showed 3 people, one of whom was high risk of falls, had been referred to the fall's clinic, care plans reviewed and equipment in place. However, it did not consider patterns around falls in bedrooms which are unwitnessed for example. Times of day, whether other factors may have contributed. Improvements were needed to proactively monitor and assess risks and reduce the likelihood of recurrence.
- People's care records lacked information, and in some examples, missed a relevant care plan. For example, risk assessments for risks of choking. Daily, weekly, and monthly notes were not completed as required, for example around people's weekly and monthly weights. Care records needed more information and detail for staff to have all the information they needed to support and keep people safe.
- Staff meetings were held regularly. We reviewed minutes which included updates on people and matters affecting the running of the service. However, key items were not discussed such as safeguarding, themes and trends, outcomes of complaints etc. The manager planned to develop a standard agenda to ensure key areas were discussed and collate staff views prior to each meeting for the agenda.

Governance and oversight did not always identify risks to people's safety or ensure all staff could evaluate and improve their practice to deliver the regulated activity in line with people's needs. People's care records and assessments were not accurately completed when required. This was a breach of regulation 17 [Good

governance] of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The new manager had recently taken up their post and had submitted their application to register with CQC. They acknowledged the improvements required and during the inspection made changes. For example, they staggered mealtimes to enable staff to focus on supporting people with their meals. They reviewed people's weights and implemented a new system to monitor bed mattress settings. However these actions need a period to be embedded and sustained before assurance of improvements can be seen.

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

● People's equality and diversity characteristics had been considered and integrated into their care plans. People and relatives told us the service was well managed and the management team were visible, approachable, and supportive. One person said, "I've not got beef about anything here at all. The management is excellent too by the way." A second person said, "This home was the best we saw by far, that's because the staff are so friendly and helpful, and the managers are great."

● Regular feedback was sought from people and their relatives through meetings, informal discussions, open door discussions with the manager and surveys. People told us they felt well informed of any changes and felt involved in the running of the home as equal partners. One relative said, "They're on the ball, we always get emails if there's anything we need to know."

● Feedback from people and relatives was positive, but a number of concerns were identified. During our observations we saw one person was sitting at a table by themselves without support to eat. People at times waited for assistance with personal care and staff did not all respect people's dignity.

● Staff did not fully promote people's choices at mealtimes by showing them the different options with no condiments on the table on the second floor with some people unable to ask for them. Staff asked people but this approach does did not promote people's independence.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager understood their responsibility under duty of candour. Duty of candour requires providers to be open and transparent with people who use their services and other people acting lawfully on their behalf in relation to care and treatment.

Continuous learning and improving care; Working in partnership with others.

● Although this inspection identified areas for improvement the manager was open and receptive to the feedback and positive about developing the service and making improvements.

● Staff were aware of the importance of working alongside other agencies to meet people's needs and liaised with other healthcare professionals such as the GP and pharmacy when required.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Safe care and treatment<br>Regulation 12 (1) (2) (a) (b)<br><br>Care and support was not always assessed, or monitored, and actions to mitigate those risks were not always in place. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Good governance<br><br>Regulation 17 (1) (2) (a) (b) (c)<br><br>Governance and oversight did not always identify risks to people's safety or ensure all staff could evaluate and improve their practice to deliver the regulated activity in line with people's needs.<br><br>People's care records and assessments were not accurately completed when required. |