Leacroft Lodge Limited

Ashcroft Hollow Care Home

Inspection report

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Date of inspection visit:
30 October 2019

Date of publication:
22 January 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ashcroft Hollow Care Home is a care home providing personal care and accommodation to 38 people. Care is provided on two floors, with bedrooms and communal areas on both floors. Some of the people are living with dementia. The service can support up to 45 people.

People's experience of using this service and what we found
People continued to be placed at risk of harm as medicines were not administered as prescribed or stored safely. Risk assessments put in place to keep people safe were reviewed however, not always followed. There continued to not always be enough staff available for people and they had to wait for support. There was a lack of governance and leadership in the service and the provider did not have effective systems in place monitor the home. The provider did not have effective system in place to learn when things went wrong.

People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

Staff understand when people may be at risk of potential harm and safeguarding procedures were followed. Infection control procedures were in place and followed. The home was adapted to meet people's needs and was clean and tidy. People's needs were assessed and care plans reflected people's preferences. When people had cultural needs, this had been considered and staff were aware of the support people needed.

People enjoyed the food available and were happy with the staff that supported them. People could make choices and were encouraged to remain independent. People, relatives and staff spoke positively about the registered manager. We received notification as required and the rating from the previous inspection was displayed in line with our requirements.

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 (18 December 2018) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough, improvement had not been made or sustained and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last six consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating. We were also following up on enforcement action we had told the provider to take.

We have found evidence that the provider needs 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashcroft Hollow Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to how risks are managed in the home. Staffing levels and people waiting for support. The understanding of capacity and consent. People's communication needs were not always fully considered. We also found concerns with the governance in the home as systems and audits were not always in place to identify areas of improvement.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Ashcroft Hollow 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are 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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included information we had received from the public. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also spoke with the local authority before and after our inspection for feedback on the home. We used all of this information to plan our inspection.

During the inspection

During our inspection we spoke with nine people who used the service and three relatives. We also spoke with five member of care staff, a visiting professional, two registered nurses and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at care records for fifteen people. We checked the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out within the home.

After the inspection
We requested further information from the registered manager in relation to their dependency tool which they provided for us.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question had deteriorate to inadequate.This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection there were not enough staff available for people and they continued to wait for support. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● There were not enough staff available for people and they continued to wait for support. People we spoke with told us they had to wait for support. Comments included, "If you want to go to the toilet you have to wait." And "Sometimes I don't think there are enough staff."
● We saw when people requested support to go to the toilet they had to wait for staff to become available to support them. We saw one person waited 23 minutes and a second person waited 30 minutes, after requesting support from staff. We saw they had both been incontinent of urine when they stood up.
● People continued to wait to be transferred with the hoist. We saw people were supported to have their slings put on and then had to wait until staff were available, so they could transfer. One person waited 24 minutes another person waited 33 minutes.
● At lunchtime there continued not be enough staff available for people. This meant people did not consistently receive the support they required.
● We saw during lunch time there were long periods where no staff were present in the dining room, offering support to people. One person shouted out for 22 minutes as they wanted a drink and there were no staff present to offer support.
● Another person had to wait between their lunch and pudding and fell asleep. Despite raising concerns, they were uncomfortable, they waited a further 23 minutes for staff to become available to transfer them back to the lounge.
● We heard call bells continued to go off during our inspection. These were not always answered in a timely manner. One person's call bell rang for 8 minutes 12 seconds until a staff member was available to respond and a second persons rang for 6 minutes 12 seconds.
● Despite call bells going off during our inspection and concerns we raised at our last inspection, there was still no monitoring of the use of call bells in the home. The registered manager confirmed they did not audit or monitor call bells.
● Since our last inspection, a new system for working out staffing levels in the home had been introduced and implemented. As we saw people continued to wait for support this meant this tool was not effective in identifying the correct amount of staff needed.

● People had individual dependency tools and had been allocated set amounts of time for tasks. These dependency tools had not fully considered all people's care needs. For example, one person had been allocated 10 minutes support for lunch, however, we saw they were supported for 18 minutes.

There were not enough staff available for people and they continued to wait for support. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We looked at staff files and saw pre-employment checks were completed before the staff could start working in the home.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure risks to people were not always fully considered or managed in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● Although people told us they felt safe and people had risk assessments in place that were regularly reviewed, we found these were not always followed to ensure people received safe care.
● We saw one person was given a drink by staff, which they drank, we saw staff did not add any thickener to this drink. At lunchtime we saw a nurse administering medicines to this person, again offered this person a drink that was not thickened. We checked records for this person which stated they required thickener in their drinks. This meant this person was at an increased risk of choking as they had not received their drink thickened as required.
● Another person's care plan stated they needed to be sat in an upright position with cushions whilst eating. Although we saw this person was sat in an upright position they had no cushions to support them. Staff realised this half way through their meal and added the cushions for support. This placed this person at an increased risk of choking whilst eating.
● When people had fallen the measures put in place to keep people safe and reduce the risk were not always followed. One person had fallen unwitnessed. It was documented they would sit in the 'observed lounge', so that staff could observed them, should they stand. We saw during our inspection the lounge where they were seated was not always observed, meaning this person was at risk of having further unwitnessed falls.
● When people had been prescribed thickener for their drinks we found this was not securely stored. We saw this was frequently left in communal areas and was stored at people's bedsides in their rooms, where people could access this. This placed people at an increased risk of potentially choking. We discussed this with the registered manager who acknowledged this happened and that a system for storing people's thickener needed to be implemented.

Using medicines safely
● On arrival we saw two people's medicines had been left on their bedside tables. One person confirmed to us these medicines were left on the table each morning. Neither people were observed by staff to take these medicines. This placed these people at risk of not receiving these medicines as prescribed. There was an increased risk that other people may take these medicines by mistake.
● When people received 'as required' medicines there was not always guidance known as PRN protocols in

place for staff to follow. This placed people at an increased risk of not receiving these medicines when needed.
● We saw one person had been prescribed medicine 'as required' for agitation. We saw they had received this for the past three consecutive days. As there was no documentation as to why the person had this medicine we spoke with the nurse who told us they had been agitated. We checked the daily records for this person which did not confirm this. Entry's included 'remains settled'. This meant this person had not always received this medicine as prescribed.

We found no evidence that people had been harmed, however, people did not always receive safe care and medicines were not always managed in a safe way. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people were happy with how they received their medicines. One person said, "The staff look after them, keep them locked away safe for me. This way I always have them when I should, and I don't forget."

Learning lessons when things go wrong
● The registered manager recorded when incidents had occurred and how things could have been done differently if they reoccurred. For example, when the lift in the home had been broken. However, as actions from the last inspection had not always been complete and improvements made when needed, we were not assured lessons had always been learnt when things went wrong.

Systems and processes to safeguard people from the risk of abuse
● There were procedures in place to ensure people were protected from potential harm. We saw when needed concerns had been raised appropriately in line with these procedures.
● Staff knew how to recognise and report potential abuse and confirmed they had received safeguarding training.

Preventing and controlling infection
● There were infection control procedures in place and these were followed. The home was clean and tidy. People or relatives raised no concerns.
● Staff told us they had access to gloves and aprons which we saw they used during our inspection.
● The provider completed an infection control audit which identified where improvements were needed. For example, there was a programme in place so that furniture could be replaced in the home.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Ensuring consent to care and treatment in line with law and guidance

At our last inspection it was unclear when people lacked capacity as capacity assessments were not always in place or decisions made in people's best interests. This was a continued breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- It continued to be unclear when people lacked capacity and if the MCA was fully understood. For example, when people had capacity to make decisions for themselves we saw some people had several capacity assessments in place to identify this.
- At our last inspection we saw documented one person 'had poor understanding due to their understanding of English', it then stated what the person's first language was [which was not English]. It was then documented the person could not understand the information relating to the decision, due to them not understanding English. The provider had not considered this person may have capacity if the information was presented to them in a format they understood. At this inspection this still had not been considered and no action had been taken, the same capacity assessment remained in place.
- When people had restrictions placed upon them this had not always been fully considered. One person had one bed rail in place to keep them safe. They also had a DoLS in place however, bedrails were not covered as part of this. The person had recently fallen from bed. The documentation stated that the person now needed two bed rails to keep them safe and prevent further falls. We saw two bed rails were up whilst the person was in bed. There was no capacity assessment in place for this or a best interest decision. The

DoLS had also not been reviewed to consider this.
● Another person had recently had their flu jab, this person lacked capacity to make this decision. There was no capacity assessment or best interest decision in place for this and this had not been considered.

We found no evidence that people had been harmed however it continued to be unclear if capacity and the MCA was fully understood. When people lacked capacity, assessments were not always in place or decisions made in people's best interests. This placed people at risk of harm. This was a continued breach of Regulation 11 (Consent to Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's gender, culture and religion were considered as part of the assessment process.
● People's physical, mental and social needs were assessed and considered.
● People's needs, and choices were met in line with national guidance and best practice. Their care plans contained information to support specific health conditions they had.

Staff support: induction, training, skills and experience
● Staff received training and an induction that helped them support people. During our inspection we spoke with a staff member who had recently started working at the home. They told us they had received an induction and had the opportunity to shadow other staff.

Supporting people to eat and drink enough to maintain a balanced diet
● People enjoyed the food available. One person said, "It's always hot and very edible."
● People were offered a choice of meals. Although on the day of our inspection it was a roast dinner and no other choice was offered. Staff told us people could request something else if they wished.
● Throughout the day people were offered a choice of drinks and snacks.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare professionals and their health was monitored within the home. We spoke with a visiting health professional who raised no concerns.
● We saw recorded in people's files when they had been seen by the GP or other health professionals. When people needed to be referred to health professionals for specific advice and guidance we saw this had been completed.
● Records we looked at included an assessment of people's health risks.

Adapting service, design, decoration to meet people's needs
● People had their own belongings in their bedrooms.
● The home had been adapted to consider people's needs. There was lift for people to use, handrails were in place around the building and hoists and other equipment were available for people.
● There was a garden area that people could access, and people told us they enjoyed using this in the summer.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Although people and relatives were happy with the care they received, people were not always treated in a kind and caring way as they had to wait for support. Staff told us they would like to spend more time with people. One staff member said, "Another staff member would allow us more time to spend with people, at the moment we are a bit rushed getting to everyone."
- We saw the support people received from staff was often when they were completing tasks with people such as hoisting or supporting at meals. There were long periods of time when communal areas where people were present had no staff available in.
- Staff knew about people's preferences and backgrounds and were able to give accounts of people.

Respecting and promoting people's privacy, dignity and independence

- As some people did not always get the support they needed to use the bathroom, people were not always supported in a dignified way.
- We saw other people's dignity was maintained. For example, when ladies were hoisted staff ensured their legs were covered with a blanket.
- Staff gave examples of how they would support people with their privacy and dignity. This included knocking on people's doors and closing them during personal care.
- People were supported to be independent. One person said, "I have a go and do what I can for myself, the girls [care staff] step in for the bits I can no longer do."
- Records we reviewed reflected the levels of support people needed.

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

- People were encouraged to make choices about their day. One person told us how they liked to get up later so staff did not come in and disturb them during this time.
- The care plans we looked at considered choices and preferences throughout and staff provided support accordingly.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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; Meeting people's communication needs

At our last inspection people's cultural and communication needs were not always fully considered. The care people received was not always responsive to their needs as records were not always up to date. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

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 careers.

- At our last inspection we raised concerns that when people did not use English as their first language this had not been fully considered, we found no action had been taken and the concerns remained the same.
- Another person had clear guidance in place around communication, we saw this was not followed during our inspection. The guidance in place for this person stated they needed to be shown their meal to make a choice. They were also to be given a choice of drinks which they could sip to try. We saw this did not happen at lunchtime.
- As at our last two inspections people who were living with dementia were not always provided with the support they required. People were asked what they would like to eat before their meal but there were no pictures, prompts or show plates used to support these people to make their choices. We did not see any signage or adaptations that would offer appropriate support for people living with dementia. For example, all bedroom doors were the same but numbered; there were no pictures or personal objects that may help people identify their rooms. There was no signage throughout the home guiding people to communal areas such as the bathrooms. This remained the same.

We found no evidence that people had been harmed however it continued to be unclear if people's communication was fully considered. This placed people at risk of harm. This was a continued breach of Regulation 9 (Person centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had information in their files which ensured staff had information available about how they communicated. Staff were able to tell us how some people preferred to communicate.
● People's cultural needs had been reviewed and considered. People had the opportunity to have foods they enjoyed. People's religious needs had been considered and the support they may require from staff with this. Staff knew what was important for people and understood this.
● Staff knew people well. People and relatives confirmed this.
● Care plans had been reviewed to ensure they were personalised and up to date. Staff told us they found care plans had the necessary information in they needed to offer support to people.

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 had the opportunity to participate in activities they enjoyed. One person told us, "There is always something to keep us entertained."
● During our inspection we saw individual activities were taking place with people. In the afternoon there was a group game of table tennis.

Improving care quality in response to complaints or concerns
● People and relatives felt able to complain. One person said, "I would talk to the staff or the manager if needed." A relative told us the registered manager was responsive to concerns.
● The provider had a complaints policy in place.
● We saw when complaints had been made the provider had responded to these in line with their policy.

End of life care and support
● When people were being supported at the end of their life. There was clear guidance in place for staff to follow. These considered people's wishes and the support they would need.
● The registered manager had recently started to work with the palliative care team to ensure people's needs were being met during this time.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection audits were not always completed. When audits had been completed they had not always identified areas for improvements. The provider also remained in breach of regulations. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection we issued the provider with a warning notice in relation to Regulation 17. We told the provider they needed to comply with this by December 31 2018. The provider had failed to comply with this warning notice.

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

Good care is the minimum that people receiving services should expect and deserve to receive. The provider has failed to implement and sustain sufficient improvements at the home to ensure good quality care and achieve a rating of good overall for six consecutive inspections. They have, alongside the local authority quality monitoring team, and commissioners and received ongoing support however, the quality of care continues to be below the fundamental standards to achieve a rating of good and is in breach of regulation of the Health and Social Care Act 2008. This meant since 2015 people have been receiving care which has consistently required improvement and may have impacted on their health, wellbeing and quality of life.

We have again found concerns there are not sufficient staffing levels within the home to meet the needs of people in a timely way. This has resulted in a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have found the principles of the MCA were not always followed. This has resulted in a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have found that risks to people are not always managed in a safe way. This has resulted in a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have found that people's communication needs were not fully considered. This has resulted in a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were some audits in place. However, these were not always effective in identifying areas of

improvements. For example, a monthly medicines audit was undertaken. This had failed to identify six 'as required' protocols were not in place.
● The systems in place to ensure staff were competent in administering medicines was not effective as we saw medicines were left on people's bed side tables.
● The provider had introduced an infection control safety cross audit. This had failed to record all infections for people that had occurred in the home. It had also failed to identify when people were having repeated infections.
● The provider had introduced a fluid safety cross audit. When people did not receive their daily recommended fluid target. No action had been taken. The provider had not followed their procedure that was in place for this.
● The dependency tool in place was not consistently effective in identifying all people's needs. There was no system in place to monitor the use of call bells in the home despite previous concerns being raised.
● There was no oversight of what was happening in the home. For example, we saw one person had not been offered a lunch time meal. We alerted staff to this. After checking, a staff member told us this was as the sheet had been signed in error to say they had eaten. This person was unable to tell staff they had not eaten.
● We saw a 'resident's quality assurance questionnaire' had been completed by people and their families in June 2019. Despite CQC identifying concerns in relation to staffing levels at the home at previous inspections there was no reference to this in the questionnaire. People were not asked for feedback on staffing levels within the home or if they had to wait for support.
● We saw three out of the 16 questions had raised concerns about staffing or the support they received. These comments included, 'Often yoghurts and the like are left for [person] to feed themselves, not possible with one arm' 'often too few carers to provide the best service' and 'just toilets not enough'.
● The analysis of the resident's survey had failed to identify these concerns or take action to resolve these.
● There was no system in place to ensure thickeners were safely stored in the home.

We found no evidence that people had been harmed however there was not effective system in place to identify concerns and drive improvement in the home. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and staff spoke positively about the management team and the support they received. One person said, "The manager is lovely, they are always here so we can ask them something if need to."

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
● Duty of candour requirements were understood by the registered manager.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Staff felt supported. They had the opportunity to raise concerns by attending team meetings and individual supervisions. One staff member said, "Things are much better than a few years ago, we have more direction now and we know what we are trying to achieve."
● The registered manager ensured we received notifications about important events so that we could check that appropriate action had been taken.
● The rating from the previous inspection was displayed in the home in line with our requirements.

Working in partnership with others

- The service worked collaboratively with other agencies to ensure people received the care they needed.

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 it continued to be unclear if people's communication was fully considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent It continued to be unclear if capacity and the MCA was fully understood. When people lacked capacity, assessments were not always in place or decisions made in people's best interests.

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 People did not always receive safe care and medicines were not always managed in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available for people and they continued to wait for support

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	There was not effective system in place to identify concerns and drive improvement in the home.

The enforcement action we took:

NOP to impose a condition on the providers registration.