Ashcroft House Care Services Limited

Ashcroft House - Leeds

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ashcroft House - Leeds is a care home providing personal care to a maximum of 32 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 27 people using the service.

People's experience of the service and what we found
People were not kept safe in the service. The provider did not always properly assess risks, and effective measures were not in place to mitigate identified risks. Actions were not always taken when incidents occurred to reduce the risk of recurrence.

Environmental risks had not always been identified, assessed, and mitigated. This placed people at risk of harm.

Care plans were unclear about how staff were to support people to reach and maintain a healthy weight. There was a lack of information about adequately monitoring people's nutrition and promptly acting upon concerns.

There were insufficient staff to support people's lifestyle choices. People were not supported to access the local community when they wished due to the lack of staff to enable this.

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

The premises was not adapted or designed to meet the needs of people living with dementia. The environment was tired, poorly maintained, and did not meet people's needs.

The provider had a poor history of compliance with this service. The need for improvements had been identified and shared with the provider at previous inspections, but they had failed to make and sustain the necessary improvements.

Whilst staff were kind and caring, failure to meet regulations and fundamental standards meant people have come to harm, received care that did not protect them from risks and have had their wellbeing compromised. This does not demonstrate a caring service.

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 this service was Requires Improvement (published 9 July 2022).

Why we inspected
The inspection was prompted in part by notification of two incidents following which a person using the service died and another person sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking and environmental risks. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement and Recommendations
We have identified breaches in relation to person centred care, dignity and respect, consent to care and treatment, premises and equipment, safe care and treatment, nutrition and hydration, staffing and good governance.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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.

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 of their 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not inadequate. Details are in our inadequate findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not 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 House - Leeds

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.

Inspection team
The inspection team consisted of 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.

Ashcroft House - Leeds is a 'care home.' People in care homes receive accommodation and care as a single package under one contractual agreement dependent on their registration with us. Ashcroft House - Leeds provides personal 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
The inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection.
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 met with key stakeholders such as the local authority to fully understand their concerns and to include these in planning for our inspection.

During the inspection
We reviewed the care records for 6 people and multiple records relating to people's medicines. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We spoke with 5 people using the service and 3 relatives. We spoke with 9 staff including the registered manager, provider and care staff.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and ensure the safety of the environment. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider remains in breach of this regulation.

- People were not protected from risks because the provider had failed to identify or sufficiently plan for risks and guide staff on how to reduce and minimise these. This placed people at risk of significant harm.
- People were not protected from the risk of choking. There was no sufficiently detailed choking care planning in place for people at risk or people who had experienced choking episodes. We were not assured staff had the knowledge and understanding to protect people from this risk.
- Oversight of risks associated with pressure area care and falls was inadequate. Records to support staff to manage this risk were insufficient. Where one person had fallen, and sustained a fracture limited care planning was in place; 30-minute observation checks to ensure their safety had not been completed.
- The premises were poorly maintained. Risks in the environment, which could cause harm to people, had not been identified and acted upon. At the last inspection, we told the provider they should take action to cover radiators to protect people from burns. At this inspection we found that this had not been done and these radiators were uncovered and scalding hot. We told the provider to take action within 7 days and returned to find they had taken action to turn these radiators off.
- There were no temperature controls on taps so water coming from the tap could reach scalding hot temperatures and cause burns. The provider had not recognised the risks associated with the stairs and had not taken any action to reduce this risk. People living with dementia had access to substances or items which could cause harm to them. For example, the key to the cleaning cupboard was left in the lock so it could be accessed. There were some products accessible in people's bedrooms, which could cause harm if ingested. One person told us they did not feel safe in the service and pointed out risks in the environment such as trip hazards, as reasons why they did not feel safe.
- One person had been injured by a falling wardrobe. Despite this incident, we found that wardrobes in the service were not affixed to the wall securely and were only attached with one screw in a bracket that required three screws. We told the provider to take action within 7 days and returned to find they had taken action to secure these wardrobes.

The provider had failed to plan and minimise risks and ensure the environment was safe. This constitutes a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our concerns, two people and two relatives told us they felt safe living in the service.

Using medicines safely
At the last inspection the provider was in breach of Regulation 12 because medicines were not managed and administered safely. At this inspection we found improvements had not been made and the provider was still in breach of Regulation 12.

● Medicines were not always administered safely and in line with the instructions of the prescriber.
● We found medicines which had been signed for but not given to people in a returns box which were due to be destroyed. Some people had not received their medicines for consecutive days. Staff responsible for administering medicines could not tell us the reason for these omissions. Quality monitoring systems for medicines had not highlighted these errors and had not supported staff to seek medical advice to determine if people were placed at risk of harm
● We observed the medicines audit being carried out by senior staff during our visit. However, they were not auditing the records against the medicines, so had not identified the medicines in the returns box that had been signed for.

The provider failed to ensure people received their medicines in line with the instructions of the prescriber. This constitutes a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection, the provider had been told to implement protocols for 'as and when' (PRN) medicines. At this inspection we found they had implemented these.
● Medicines were stored securely and audits were carried out to monitor the temperature of the medicines room to ensure medicines were kept within the correct range.

Staffing and recruitment
At the last inspection we recommended the provider review staffing levels as there were insufficient numbers to ensure people had access to meaningful engagement and that their social needs were met. At this inspection we found the provider had not made improvements in this area.

● There were not enough staff to support people safely. People told us there were not enough staff to support them when they needed it. One person said, "There is not enough staff and sometimes you can't find anybody and if there is two on you can't find anybody."
● There were insufficient staff to meet people's social and emotional needs at all times. There was no dedicated member of activities staff, so the care staff were expected to undertake these duties. However, they did not always have time to do so as they were supporting people with other tasks. Staff told us they would like to have time to spend with people, but this was rare as they had so many other tasks to complete.

● One person had raised in a meeting they wanted the opportunity to go out more and were told this would be possible when there were more staff. However, the registered manager confirmed to us this person had not been taken out by staff since October 2023. The registered manager also confirmed that people had not been offered an opportunity to go out on a trip since September 2023. This meant we were not assured the staffing level was sufficient to protect people from the risk of social isolation and boredom.

The provider failed to deploy sufficient staff to meet people's needs, including social and emotional. This constitutes a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated safe recruitment procedures.

Learning lessons when things go wrong
● At the last inspection the service was rated requires improvement and the provider was told to make improvements in a number of areas. At this inspection we found the provider had not made improvements and the service had deteriorated in quality.
● Two people had come to harm and the provider had not learnt from these incidents and taken action to ensure the risk of repeat incidents was reduced.

The provider failed to learn lessons when things went wrong. This constitutes a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
● People using the service were not protected from the risk of abuse.
● Staff had received training in safeguarding. However, we found an incident had occurred and none of the staff present reported this to the registered manager or made a safeguarding referral. This meant we were not assured that staff protected people from abuse.

The provider failed to ensure staff understood their responsibilities in reporting safeguarding concerns. This constitutes a breach of Regulation 13: Safeguarding people from abuse or avoidable harm of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The care home was mostly clean throughout. However, the poor state of fixtures and fittings in some areas of the premises meant that effective cleaning was not possible.

Visiting in Care Homes
● People were able to receive visitors without restrictions in line with best practice guidance.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support, and outcomes.

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

- People at risk of malnutrition were not effectively supported to manage this risk. They were not weighed regularly, and we noted significant gaps of several months for people at risk of weight loss. One person who was underweight had not been weighed since September 2023. The hospital weighed this person on admission in January 2024 and this showed they had lost 4.2kg since they had last been weighed.
- Care plans to support staff to deliver the most appropriate care to people did not contain up to date information about recommendations from health professionals or prescribed nutritional supplements to aid weight gain. People who needed cream short and milkshakes daily did not receive them. Records to monitor food intake for people at risk did not demonstrate they were offered regular snacks between meals to boost their intake.
- The provider was not using industry recognised tools such as the Malnutrition Universal Screening Tool (MUST) to calculate people's risk of malnutrition. This meant that staff did not benefit from the guidance which goes with each score which indicates what action they should take to protect people from the risk of malnutrition.

The provider failed to ensure people were protected from the risks of malnutrition. This was a breach of Regulation 14: Meeting nutrition and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the concerns we had around nutrition, people told us the food was of good quality and they enjoyed it.

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

- People's needs were assessed when they came to live at the service. However, these were not always reassessed on an ongoing basis to monitor whether their needs were changing. Care plans did not reflect best practice guidance such as that provided by the National Institute of Health and Care Excellence (NICE) as they were too brief and did not instruct staff on how to care for people.

The provider failed to ensure continual reassessment of people's needs and that care records met best practice guidance. This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's individual needs were not met by the adaption, design and decoration of the premises. Many of the corridors were plain which made it was harder for people living with dementia to navigate around. There was nothing identifiable on many people's bedroom doors so they could identify their bedroom easily. There were no items of interest or stimulation for people to access independently as a source of engagement. The service had chosen to begin caring for people living with dementia but had not adapted or designed the building to meet the needs of these people or protect them from risks.
● At the last inspection the provider told us they were making improvements to the environment and were redecorating. However, over a year and a half later the service is still not adapted or designed in line with best practice guidance and remains in a poor state of decoration.

The provider failed to ensure the environment was suitable for those they provided care to. This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

● Staff did not have a good understanding of the Mental Capacity Act and how they should apply this in their role. People were not always enabled to make choices according to their ability and to maintain control of their own lives. People told us staff did not always let them make decisions and they felt pressured by staff to do things at a time that was convenient for them. For example, people said they did not have a choice in when they got up or went to bed. One person said, "You can't make your own choices, you get up when they say." Another person said, "The staff can be a bit bossy."
● Staff had received training in the principles of the Mental Capacity Act but the provider had not identified that staff were not acting in line with this training.
● There had been a delay in making Deprivation of Liberty Safeguards (DoLS) applications which meant some people under constant supervision by staff and without the freedom to leave the building did not have the legal paperwork to support that this was in the person's best interests.
● Care plans did not set out how people could consent to their care and did not always reflect people's consent to their care and treatment.
●Formal best interest's processes had not always been followed and staff had made decisions in people's best interests without following proper process. This meant people and their relatives had not been involved in making decisions about their own care.

The provider failed to ensure staff acted within the principles of the Mental Capacity Act. This was a breach of Regulation 11: Consent to Care and Treatment of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

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

● Where staff made referrals to other professionals when required to support people, they did not always transfer the guidance and instructions given, into care planning which meant staff could not act in line with these.

We recommend that instructions received by external healthcare professionals be written into care planning and that staff are made aware of these instructions so they can be fully implemented.

Staff support: induction, training, skills and experience

● Staff had received training in subjects appropriate for the role but did not always demonstrate a good knowledge of subjects they had received training in. For example, staff did not always follow the principles of the Mental Capacity Act despite having received training in this subject. Staff practice had not been monitored and their competency assessed on a regular basis. This meant that shortfalls in training had not been identified.

●Supervision and appraisal of staff had not always been completed so we were not assured that staff were being encouraged and supported to develop in their role.

We recommend that the provider ensures better oversight of staff competency and monitors staff practice more closely to identify areas for improvement.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion, kindness, dignity and respect.

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

● The service was not caring. Whilst some staff were intuitively caring, the provider and registered manager had allowed people to be continually exposed to the risks of poor and inappropriate care and had failed to take action to improve standards of care. This does not demonstrate a caring service.
● People told us they were not always treated with kindness and that staff displayed frustration with them. One said, "If people are awkward with [the staff] they can get nasty." Another person told us, "Usually I know the staff, but they can be a bit off." One other person said, "They do get hairy sometimes and a bit stressed."
● An incident occurred where a member of staff had sworn at a person using the service. The staff member themselves, nor any of the other staff present reported this to the registered manager or provider. None of these staff made a safeguarding referral. This indicated that staff did not identify anything wrong with the culture of the member of staff.

The provider failed to ensure staff at all levels treated people with kindness. This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
● People were not always supported to express their views and make decisions about their care.
Care records did not consistently reflect people's thoughts, feelings or wishes on their care. Care records were not person centred enough and did not reflect people as individuals.
● There was not always evidence of people or their relative's involvement in care planning. People told us they were not aware of their care plan or what was written about them. One said, "They don't discus my care plan." Another person commented, "They did discuss it at first but never again."

The provider failed to ensure people were supported to express their views and were involved in care planning. This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
● People's privacy, dignity and independence were not always respected and promoted.
People and relatives told us there had been a long-term issue with the laundry which meant they did not receive their own clothes from the laundry and other people's clothes were put in their wardrobes and offered to them to wear. One person said, "The clothes get mixed up in the laundry." This person stated that

when they went to the laundry to ask about their missing clothes, staff were rude to them and told them to 'get out.' Whilst many people using the service could identify their own clothing, some people living with dementia may be unable to. Therefore, there was a risk of people being dressed in clothing which did not belong to them. This would not support their dignity and respect.

● People told us that staff did not always respect their privacy when entering their bedrooms. One person told us they felt they had little privacy living in the home.

The provider failed to ensure peoples dignity and respect was promoted. This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- People were not supported as individuals, in line with their needs and preferences.
- Care records were not personalised to reflect people's diversity and individuality. Some preferences were included, but these were often limited and there was no information about people's routines or how they wished for their care to be delivered.

The provider failed to ensure that person centred care was planned and delivered. This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities.

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.

- The provider was not meeting the Accessible Information Standard. People's communication needs were not fully understood and supported.
- People's communication methods were not always recorded in their care records.
- Information was not adapted to ensure people could access it. People living with dementia were not always supported to make visual choices. For example, they were not shown the food options they could choose from, nor were picture images available.

The provider failed to ensure people's communication needs were met. This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities.

End of life care and support

- End of life care planning was not sufficiently detailed. For some people, no preferences were recorded. For other people who were in the end stages of their life, there was no information about the complex care they would require at this time to ensure they had a comfortable and pain free death.

The provider failed to ensure adequate planning for people coming to the end of their life. This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulated

Activities.

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 were not supported to maintain relationships, follow their interests, or take part in activities that were relevant to them.
- People were largely disengaged with little source of engagement or stimulation available. Care staff told us they did not have time to sit with people and engage with them, and this confirmed our observations.
- There were few sources of activity around the care home that people could access independently. For example, books, games or craft materials. There was a lack of stimulating items people living with dementia could access to keep them engaged.
- People had not had the opportunity to take trips outside of the service since September 2023, despite having requested this. This means people were placed at the risk of boredom and social isolation.
- Care records did not make clear the support people required to reduce the risk of social isolation and engage in activity. Information for staff about what people enjoyed was not always included in their care records.

The provider failed to ensure people had access to enough sources of activity and engagement. This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities.

Improving care quality in response to complaints or concerns

- There was a complaints procedure in place and people told us they knew how to complain.
- People said they felt that any complaint they made would be listened to.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to operate a robust quality assurance system. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider remains in breach of this regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider did not have a system in place to provide person-centred care that achieved good outcomes for people. The culture of the service was not open or positive. People were not supported to live their lives in the way they wanted.
- People were not consistently protected from the risks of harm. Poor practices were not addressed. Learning from incidents did not take place. People experienced shortfalls in their care. Staff at all levels failed to protect people from harm.
- People were not empowered and experienced poor outcomes which compromised their health and welfare. People told us staff were not always kind to them and they were not in control of their lives.

The provider failed to ensure a culture that was person centred, open, inclusive and empowering. 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; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements and continuous learning and improving care

- Quality assurance systems did not lead to continual improvement. A system of auditing was in place; however, it was ineffective because they did not always highlight where improvements were needed. Where areas for improvement had been identified, they had not always been addressed or sustained.
- The provider had been told to make improvements in a number of areas at their last inspection in May 2022. Despite this, they had failed to make the improvements required and the quality of the care provided to people had deteriorated in between these inspections.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Feedback was not consistently sought or acted upon. People and their relatives were given the opportunity to participate in a survey of their views and in meetings. However, meetings were not regularly carried out; meeting minutes were only available for 2 meetings since January 2023.

● People's feedback had not always been acted upon in a timely way. For example, people had expressed views in meetings such as wanting to go out more but there was no evidence this had been taken forward by the provider and people hadn't been offered the opportunity to go out since September 2023.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The provider did not always work effectively in partnership with others.

● Where advice had been provided by external healthcare professionals, this did not always lead to changes in care planning for people and care delivery.

● The provider had been advised against admitting one person to the service by the local authority safeguarding team. Despite this advice they still admitted the person. This meant we were not assured the provider listened to other professionals.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always supported in a kind and caring way by staff. The environment was not appropriate for the people using the service and people's views and feelings were not always reflected in their care records. People's communication needs were not always planned for and there was insufficient care planning for those coming to the end of their life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with kindness, dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People told us staff did not allow them to make decisions consistently and that they did not have control over their lives. Staff did not demonstrate a good knowledge of the Mental Capacity Act. Care planning did not make clear how people could consent to their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient

numbers of staff to meet people's needs.