A Carnachan

Ashford Lodge Nursing Home

Inspection report

1 Gregory Street
Ilkeston
Derbyshire
DE7 8AE

Tel: 01159307650
Website: www.ashfordlodge.com

Date of inspection visit:
07 July 2022

Date of publication:
18 May 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Ashford Lodge Nursing Home is a residential care home providing personal and nursing care to up to 20 people. The service provides support to older people, younger adults and people living with dementia. At the time of our inspection there were eleven people using the service.

People's experience of using this service and what we found
The service was not well-led. The management arrangements were not clear. There was no effective governance system and improvements since the last inspection were not sufficient to meet the requirements of regulation.

There were widespread concerns about safety. When people had accidents, there was no review or follow up to see how to prevent the same thing happening again. Staff were not provided with effective guidance to know how to keep people safe from harm. Some people had lost weight and no action was taken. Some areas of the home were visibly unclean. Medicine procedures were not always in line with best practice guidance.

Staff were not supported to undergo effective training. There was no training to know how to communicate effectively with people. People were not supported to have drinks at mealtimes until they had finished their food. There was limited choice of food at mealtimes. Information in people's care plans was not always in line with best practice guidance.

At times, people's dignity was compromised. People did not have access to outside space. The main lounge and the quiet lounge were cluttered, and many areas were in a state of disrepair including frayed carpets that posed a trip hazard.

People's care was not always planned or delivered in a person-centred way. There were practices in the home which were designed to be easier for staff rather than to meet the needs and preferences of the people who lived there. Care staff were kind and caring towards people, however, they were busy and had to carry out tasks throughout the day, so had limited time to offer companionship to people.

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

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

Rating at last inspection and update
The last rating for this service was inadequate (published 5 March 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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 are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches of regulations in relation to leadership and governance, safety, person-centred care and staff training.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains 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.

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 safe. Details are in our safe 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 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**

Ashford Lodge Nursing Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by one inspector 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
Ashford Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Ashford Lodge Nursing Home 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager. However, they were not acting as the manager

at the time. The provider had taken over as the acting manager.

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. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with eight members of staff including the provider, clinical lead and care staff. We spoke with four people and two of their relatives about their experiences of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed seven people's care records, multiple medicine records, three staff files and other records relating to the running of the home.

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 inadequate. At this inspection the rating has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to implement systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. 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

Learning lessons when things go wrong

- The provider did not always carry out a review after people had accidents or near misses.
- One person had suffered three unwitnessed falls in quick succession. There was no review of the accidents or updated assessment to guide staff how to protect the person from the same thing happening again. Shortly after, the person suffered another fall and sustained a serious injury.
- We discussed this with the provider, and they told us they would only carry out a review of an accident if it was serious. This means they had failed to identify opportunities to reduce the risks to people's safety and prevent people from experiencing avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people's safety were not always assessed or mitigated. This placed people at risk of harm.
- The provider had failed to respond when people lost weight. We identified four people who had lost weight since the last inspection. One person had lost 2.6kg in one month. Another person was not weighed in February or June 2022 and in July 2022 was found to have lost 3.9kg. The provider had failed to ensure reasons for weight loss were considered or people's weight was monitored more frequently.
- The guidance for staff to follow in the risk assessments in people's care plans was not always clear. For example, one person's risk assessment stated they did not have any breathing problems. Later in their care plan it stated they used an inhaler and had a history of a serious respiratory infection. Therefore, staff were not guided how to monitor and care for this person safely.
- At our last inspection we identified a person was at risk as they were left unsupported in a wheelchair platform lift. At this inspection we saw there was still no guidance for staff or risk assessment around the use of this lift.

Using medicines safely

- Medicines were not always safely managed. The provider was not always working in line with their own medicines policy.
- Where people refused their medicines and were supported to take them without their knowledge (known as covert), the provider had failed to ensure there was pharmacy advice about how to safely administer the

medicine. This is required by national guidance and was recommended in the provider's medicine policy.
● Where people took medicines on an as and when basis (known and PRN), the provider had failed to ensure there was always a protocol to guide staff how and when to support people to take these. This is required by national guidance and was recommended in the provider's medicine policy.
● We identified two people's medicines stock counts were incorrect. This was because staff had not always recorded the quantities of tablets they had supported people to take.

Preventing and controlling infection
● The provider was not always preventing visitors from catching and spreading infections. This was because there was no PPE available at the entrance. People had to walk through the home before being provided with PPE.
● The provider was not always promoting safety through the layout and hygiene practices of the premises. Many areas of the home were in a state of disrepair, with broken tiles and chipped paintwork. This meant it was not possible to clean these areas effectively. We saw some areas of the home were visibly unclean.
● We were not assured that the provider's infection prevention and control policy was up to date or that they were working in line with the guidance in the policy. For example, the policy recommended high touch points were cleaned every two hours. We found this was only happening twice a day.

The provider had failed to implement systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. 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.

● We were somewhat assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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

Relatives told us they were welcome to visit their relations when they chose. The provider told us they ensured they provided quiet areas of the home for people to enjoy companionship with their visitors.

Staffing and recruitment
● Staff were not always deployed effectively to meet people's needs in a timely manner.
● People had to wait for their needs to be met, or for staff to spend time with them, particularly after meals. This was because care staff were busy supporting other people.

We recommend the provider review their deployment of staff so people can have their needs met in a more timely manner.

● No staff had been recruited since the last inspection. At the last inspection we found the provider had not completed comprehensive background checks on staff before they were employed. For example, there were not always full education or employment histories recorded. The provider had failed to make efforts to gather this information since the last inspection. The provider had ensured staff had criminal records

checks.

Systems and processes to safeguard people from the risk of abuse

● We reviewed a safeguarding referral that had been made and saw the provider had made the referral in line with their safeguarding policy. However, they had failed to include relevant information about the person's recent history which would have alerted the safeguarding officer to potential avoidable harm.

● There was a safeguarding policy in place. However, this did not include guidance for staff about how they could report safeguarding incidents to external professionals. When asked the provider did show us there was a safeguarding poster on the wall in the home with this information for staff.

● Relatives told us they felt their relations were safe. One relative said, "[Name] is safe here, they weren't safe before, it eases my mind that they are well cared for."

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 inadequate. At this inspection the rating for this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection the provider had failed to ensure staff were competent. This was a 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

Staff support: induction, training, skills and experience

- The provider had not ensured staff were supported to complete enough training to enable them to carry out their roles effectively.
- One person had a learning disability. The provider had not ensured staff had completed training to know how to interact with people with a learning disability or autism which was a legal requirement. We saw occasions where some staff did not communicate with this person in line with the guidance in their care plan.
- The training modules offered to staff were not in line with the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. Only four of the eleven staff members had completed this.
- Although staff had completed training since the last inspection, there were still staff who had not completed training in supporting people living with dementia or diabetes and did support people with these needs. The clinical lead had not completed training in care planning and was responsible for writing and reviewing people's care plans. Staff did not complete training in equality and diversity.

The provider had failed to ensure staff were supported to complete training required to support people effectively. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to assess people's needs and plan their care and the environment did not always facilitate person centred care. 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were not always supported to have their healthcare needs met.

● The provider could not demonstrate people were supported to have their oral care needs assessed or met. Each person had an oral care assessment in their care plan. These all recommended an oral care plan be implemented, this had not been done for anyone.

● People's care records did not include when they had or had not been supported with oral care. Therefore, it was not clear if people were supported with this or not.

● Guidance in people's care plans was not always in line with best practice guidance. For example, one person was known to experience vacant episodes. The guidance in their care plan did not explain what could trigger these, how the person was known to present, how long they may last or how staff were to care for this person if and when these happened. This placed this person at risk of receiving unsafe care.

● Another person was known to have experienced seizures and there was no guidance for staff about these in their care plan.

● Commissioning bodies had advised the provider about improvement needed to people's assessments and care plan guidance. The provider had failed to act on this advice.

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

● The provider had not ensured people always had access to food and drinks, or that their nutritional needs and preferences were met.

● People were not able to have drinks whilst they ate. We observed a mealtime and saw people ate their food first and were given drinks after they had finished eating. A staff member and the provider confirmed this was normal practice. The provider told us this was to make sure people did not spill their drinks at mealtimes.

● There were people living there who lived with diabetes. There were no specialist diabetic foods in the building. We asked staff why this was, they told us that people with diabetes just did not have sugar. No effort had been made to buy diabetic alternatives such as jams, marmalades, biscuits or chocolates.

● One person asked for a cup of cocoa, the staff member supporting the person refused this and said they only had tea. The person was then given a drink of juice. In the kitchen we saw there was chocolate drink powder that could have been used to make the person the drink they had asked for.

● People were not given real choice for their lunchtime meal. The options were baked potato with cheese or tuna. This did not offer a choice to people with limited capacity to ask for things if they did not want a jacket potato that day. The provider told us there were other options available and they would remind staff to offer alternatives.

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

● The facilities and premises did not meet people's needs or allow them to maintain independence.

● There was no outside space for people to enjoy. There was one bench in the front garden, but this had not been maintained. The provider told us they used to do things outside but that was no longer something they did with people.

● On the day of the inspection it was hot and sunny outside, and no effort was made to offer people the opportunity of fresh air.

● There was no signage or other adaptations to enable people living with dementia or sensory loss to easily navigate the building.

● Many areas of the home remained in a state of disrepair. For example, carpets were frayed which posed a trip hazard.

● Some areas of the home remained cluttered. In the main lounge, people's chairs were so close together

that there was not room for staff to stand at the side, this meant it would not always be possible to support people safely with moving and handling.
● There was an area known as the quiet lounge. This was cluttered with boxes of things including glue cartridges and glue gun, COVID-19 test kits, nail varnish, clothes and toys. This was also the area where staff on duty stored their personal bags and coats.

The provider had failed to assess people's needs and plan their care; the environment did not always facilitate person centred care. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider contacted us and demonstrated they had now introduced signage around the home for people living with dementia or sensory loss. They also included a newly implemented oral care policy.

At our last inspection the provider had failed to ensure people's rights were upheld. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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.

● The provider had ensured that people's abilities to make decisions were assessed in line with the MCA. People were not deprived of their liberty.
● However, there were not always records of these available in people's care plans. This meant staff were not able to use them to guide their practice. The provider was able to find them stored electronically when we asked.
● There were some records that demonstrated how decisions were made in people's best interest and staff knew when people's relatives were legally authorised to make decisions for them.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we did not review this key question. At the previous inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always supported in a person-centred way. People's care plans contained outdated language that guided staff to restrict people's independence. People's dignity was not promoted.
- Two people were supported to eat their meals in the dining room in their wheelchair. Whilst they ate the footplates of their wheelchairs were removed which left their feet dangling. This compromised their dignity and did not look comfortable. The provider told us they did this to create more room under the table. This means this was not considered in the best interest of the people but was standard practice in the home.
- One person's care plan stated, 'remind [Name] of their limitations.' This person was able to be quite independent so this guidance for staff did not promote their independence.
- Another person's care plan stated, 'Sometimes I slide out of the chair, this is an act not a fall.' This did not explore why the person may slide out of their chair or how staff could prevent this from happening.
- One person had guidance in their care plan stating they should be supported with cushions when in their wheelchair as they would likely slump to one side. We observed them to be slumping over to one side during lunchtime and staff had not supported them with the cushions.
- Although care staff were kind and caring in their approach with people, they were also busy, and task orientated. We saw prolonged periods of time when staff were in the communal lounge in a purely supervisory capacity and not offering companionship. One staff member said, "I have to be in lounge to supervise people."

The provider had failed to assess people's needs and plan their care; the environment did not always facilitate person centred care. This was a continued breach of Regulation 9 (person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection, there had been improvements in the promotion of people's privacy. People no longer shared bedrooms.
- Some care staff did ensure they made time and effort to engage with people and interact with people in a way that they enjoyed.

Ensuring people are well treated and supported, respecting equality and diversity
- People's needs in relation to their cultural beliefs and preferences were known. However, it was not clear how the provider supported people to follow these.
- For example, one person's care records showed they had been religious throughout their life. There was no documented evidence of how the provider supported them to continue to follow their religion.

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

● People and their relatives were supported to express their views and make decisions about their care.

● One person was supported with their independence. They had written their care plan themselves and were soon moving to their own home.

● Relatives told us they felt listened to. One relative said, "I was involved in writing the care plan, I don't know if it has been updated recently but [Name] is happy and is getting all the care they need."

● A different relative said, "The staff are kind and have a laugh with [Name]. They have a nice relationship with me as well."

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 did not review this key question. At the previous 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.

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

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 Accessible Information Standard was not met. People's communication needs were assessed, but there was no clear guidance about how to meet these. Where there was guidance, this was not always followed and may not have been up to date.
- One person's care plan stated, 'My ability to communicate is almost non-existent, facial expressions are mostly non-existent.' Later in their care plan, staff were guided to give this person pain relief if they expressed they were in pain. There was no guidance about how they would express this to staff.
- A different person's care plan guided staff to use pictures and symbols to communicate. These were not used during this inspection.

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 always supported to take part in activities or follow their interests.
- The provider did employ an activities co-ordinator, but they also worked as care staff. During the inspection we saw there were no planned activities and limited social interaction for people. Two people were provided with books for puzzles and colouring and one person had books to read. The activities records had only been completed for five people and each entry stated they had sat in the lounge and watched television.
- A staff member told us there was not enough for people to do, they said, "The residents don't do enough but I think they're happy in the lounge watching telly."

The provider had failed to assess people's needs and plan their care; the environment did not always facilitate person centred care. This was a continued breach of Regulation 9 (person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives felt there were activities that people enjoyed. One relative said, "They have a person that does activities, they did a jubilee tea party, they stuck a flag in [Name's] hand and they waved it about a bit. I'm

not sure what other things they do."
● A different relative said, "The activities staff will sit and chat to the people."

End of life care and support
● The provider had not always ensured there was enough information about how people would like to be cared for if they were to approach the end of their lives.
● When people had made decisions that they would prefer not to be resuscitated this was clearly documented in their care plans. However, this just included if people would prefer to go to hospital or not. There was no information about how to support people to be cared for in the way they chose if they were to become seriously unwell.

Improving care quality in response to complaints or concerns
● The provider did have a complaints policy in place which guided the reader how to make a complaint. There was information around the home about how to make a complaint.
● Relatives told us they would feel confident to raise a compliant and felt sure it would be dealt with appropriately. One relative said, "I can't fault the staff, any concerns I would go to the manager."

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 inadequate. At this inspection the rating has remained the same. 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.

At our last inspection the provider had failed to ensure there was effective governance and leadership. This was a breach of regulation 17 (Good Governance) 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 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Management and governance arrangements were not clear. Leaders did not understand regulatory requirements or best practice.
- Since the last inspection, the management arrangements had changed. The provider told us they were the acting manager and the registered manager was now there in a clerical and advisory capacity. Relatives referred to the registered manager as the person in charge. One staff member told us they didn't know who was in charge anymore, they said, "We don't know who the manager is, we are kept out of the loop."
- The provider had failed to implement effective governance systems. Some audits were completed but they were not used to drive forward improvements and had not identified the issues we have found during this inspection. The manager told us that audits of medicine records were completed monthly, but when asked they were not able to find the last six months of audits.
- Audits of accidents and incidents were completed, but they were not used to drive forward improvements in safety. The audits identified how many accidents and incidents had happened, but not how to reduce the risk of these happening again.
- When staff handed over to each other at the start and end of their shift they had verbal conversations about people. However, no documented records were made or kept. This system was not effective as it relied on staff remembering what had been discussed. One staff member said, "Handovers aren't done, we find things out incidentally because we tell each other."
- Some records relating to people's mental capacity could not be found in care plans. The registered manager then found these stored electronically. This meant that the assessments were not available for staff to review when supporting people.

Continuous learning and improving care; Working in partnership with others

- The provider had failed to implement enough improvement to be compliant with regulations since the last inspection.

● The provider had been supported by commissioners but had failed to always make improvements based on their recommendations.
● The provider had not sought other external advice to support them to drive forward improvements.

The provider had failed to ensure effective governance and leadership. This was a continued 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
● The duty of candour was not always met. Although the provider did inform people's relatives when things had gone wrong, this did not always include all the relevant information or an apology.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The management team had not created a culture of high-quality person-centred care. Therefore, people did not achieve good outcomes from their care.
● There was a lack of stimulation and activities available to people. People were not offered variety to their day. The care relied on the same regimented pattern of spending days in the communal lounge and going to the dining room for meals.
● Despite the widespread concerns identified at this inspection, feedback we received from people's relatives was positive. One relative said, "It's ok, it's very homely, I would recommend the home to others." A different relative said, "I can't think of anything they could do better, I am happy that [Name] lives there."

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to assess people's needs and plan their care; the environment did not always facilitate person centred care.

The enforcement action we took:

Continuation of Notice of Proposal to Cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to implement systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

Continuation of Notice of Proposal to Cancel

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	The provider had failed to ensure there was effective governance and leadership.

The enforcement action we took:

Continuation of Notice of Proposal to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had failed to ensure staff were supported to complete training required to support people effectively.

The enforcement action we took:

Continuation of Notice of Proposal to cancel