Continuum Healthcare Limited

Ashcroft Nursing Home

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ashcroft Nursing Home is a residential care home providing personal care for up to 40 people. At the time of our inspection there were 28 people using the service. The service provides support to people with a range of needs, including those living with dementia. The service had stopped providing nursing care at the time of our inspection.

People's experience of using this service and what we found
People did not always receive safe care because risks were not properly assessed or mitigated. There were not enough staff deployed to meet people's needs in a timely way and staff did not have up to date training to support people safely and in person-centred ways. The home was in the process of being refurbished, but some aspects of the building, furniture and equipment were not safe. People were not safely supported with their medicines.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not fully support this practice. We made a recommendation for staff to consistently involve and include people in decision making, in line with the principles of the MCA.

Care staff worked hard to try to meet people's needs and they were kind and caring in their approach. Activities were not offered in ways which were meaningful to people and some people were not appropriately stimulated. Records of people's care and support were not always completed or known by staff, to ensure the care people received met their needs. People's relatives said they thought their loved ones were safe and well cared for overall. They trusted the staff, although expressed concerns about staffing levels.

People, families and staff were not always involved and informed about their care, or what took place in the home. We received mixed views about the quality of the communication in the service. Some relatives reported no concerns at all, whilst others said they thought there had been a recent decline in the standards and quality of care management and communication from the manager. We made a recommendation the provider seeks and acts on feedback and uses this information to improve the service.

There were significant weaknesses in the leadership and management of the service. There was poor internal communication and oversight of risk. Quality checks lacked rigour, and there was no robust or consistent oversight of the service delivery.

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

Rating at last inspection
The last rating for the service was Good, (published on 1 March 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection was prompted in part due to concerns received about the environment and the quality and safety of the care provided. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the safe management and quality of people's care, so we widened the scope of the inspection to become a comprehensive inspection which included all the key questions.

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.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
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 in relation to people's care, safety, staffing issues and how the service is managed.

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. 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 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Ashcroft 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
The service was inspected 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
Ashcroft Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashcroft Nursing Home is a care home with nursing care, although they had ceased to provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. A manager had been in post for 11 months and had submitted an application to register. We are currently assessing this application.

Notice of inspection

This inspection was unannounced.

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

During the inspection
We spoke in person with 4 people who used the service and 3 relatives about their experience of the care provided. We spoke with 8 further relatives by telephone. We spoke with 6 members of staff, including the head of care, care staff and ancillary staff. We carried out observations of care.

We reviewed a range of records. This included 2 care records in detail and a sample of several other care records to check on how risks were recorded. We looked at multiple medication records

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested some documentation to be sent for us to review remotely.

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 good. 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; Learning lessons when things go wrong

- Risks to people were not robustly assessed and monitored, or measures put in place where there were known hazards. Staff had not received training to support them to assess and mitigate risks to people.
- Staff did not always understand people's risks or how to ensure safe care. For example, one person needed a diabetic diet, yet this was not provided and there was no care plan for their diabetes. Staff were not always able to identify where people were at risk of pressure injuries or how to support them safely, such as with regular repositioning.
- Where people were at risk of weight loss, this was not monitored to ensure they received sufficient support. There was no consistent evidence of actions taken where people had lost weight and where their care records stated they were at 'high risk' of malnutrition. For example, recording of food and fluid was not consistently completed and the frequency of weight checks was not increased.
- There was a refurbishment process in place, but there was insufficient oversight of the safety of the premises and equipment. Some equipment, fixtures and fittings were broken. For example, some people's wardrobe doors and drawers were loose or damaged and one person was using a broken bed. Some people complained of feeling cold, to which we requested an immediate room temperature increase. People's personal emergency evacuation plans were not all completed or accurate.
- We were not assured of any lessons learned. For example, the, local authority had visited the service prior to the first day of our inspection, yet the concerns they found had not been addressed. Furthermore, many concerns identified at the inspection had not been addressed by the time the local authority visited two weeks later.

Systems had not been established 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 breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- The provider could not demonstrate people received safe support with their medicines.
- People's supplies of medicines did not always correspond with the records of what they had been given. A sample of medicines we checked showed there were either fewer or more medicines than the amount recorded, and staff were unable to account for discrepancies.
- Where topical creams were prescribed, it was not always indicated on the records where on the body these needed to be applied. One person had been prescribed cream for a skin condition one week before our inspection. This cream was stored in their medicine cupboard but was still sealed there was no record to show it had been given.
- We were not assured people received appropriate pain relief. One person had a stock of two pain patches, yet the records showed these had been applied. Another person was prescribed paracetamol, but there was

none in stock for them.
● For medicine needed 'as directed' or 'as required' there was not always clear guidance for staff to know when or why this may be needed. Some people's medicine records did not have their photograph on for staff to cross check when supporting them with their medicines.
● Staff were not fully confident in their abilities to support people with their medicines, although they understood when people might need additional support or referral to their GP. None of the relatives we spoke with expressed any concerns about medicines.

Systems had not been established to ensure the safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections.
● PPE was not always used effectively or safely as staff frequently touched their face masks.
● There was regular cleaning taking place, although this was not effective because parts of the home had dirty walls and flooring. The service was not operating in line with safe IPC guidelines for colour coded cloths, mops and buckets. The fridge was not clean and we asked for some out of date and unlabelled food to be thrown away.
● Some equipment was particularly dirty. For example, there was dirt and debris ingrained on people's wheelchairs. The head of care said this task was meant to be completed by night staff and they would make sure this was addressed. On day two of our inspection, wheelchairs had not been cleaned.

Systems had not been established to ensure the prevention and control of infection. This placed people at risk of harm. This was a breach of regulation 12(1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels were not sufficient to meet the needs of individuals. People had to wait considerable lengths of time for their basic needs to be met because staff were busy supporting others. Staff said, "We know people are waiting too long and we are trying to do our best." Some communal areas were not sufficiently staffed which meant people were unable to summon support. Relatives told us they had to wait for staff to answer the door to them.
● Some people, relatives and staff said they thought staffing levels could be improved, particularly where people were living with dementia. One relative said, "The level of staffing has gone down, they are stretched, they are juggling too many things, and this has impacted on the care as they don't have enough staff to give people the attention they need. Several of the regular [staff] are no longer there and there are new ones. My [relative] was sat in wet clothes in their wheelchair, the staff hadn't noticed that."

There were insufficient numbers of staff deployed to meet people's care needs. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider gave assurances they had increased staffing levels immediately following the inspection visit.

● Some relatives told us the home was adequately staffed. One relative said, Yes, I'm fine with the numbers of staff there" and another relative said, "Yes. there are always plenty of staff about."
● Recruitment procedures were in place and the provider was actively trying to increase the number of staff

in the team. The manager gave assurance they had made improvements to their recruitment processes to ensure staff checks were satisfactorily completed before they worked unsupervised.

Systems and processes to safeguard people from the risk of abuse

● There was mixed staff knowledge about how to identify and act upon information of concern. Not all staff were confident in the safeguarding procedures to protect people from the risk of abuse.

● The safeguarding policy and procedure contained out of date information and guidance which was superseded in 2015. Not all staff knew there was a safeguarding policy.

● We were not assured accidents and incidents had been appropriately referred to the local safeguarding adults' team, or to CQC as required.

Systems for safeguarding people were not robust enough to ensure people were protected. This placed people at risk of harm. This was a breach of regulation 13(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- The home was not well adapted to meet the needs of all the people living at Ashcroft Care Home, although there was refurbishment taking place. There were limited resources for people to access to support their meaningful occupation, hobbies and interests.
- Communal lounges lacked suitable seating. Chairs positioned at tables were not always supportive of people's physical needs as these were hard surfaced. Some people sat to tables in their wheelchairs. Softer seating within communal areas did not always offer sufficient support. For example, people could not always sit comfortably due to them sliding down on the washable surfaces of the seating.
- People's individual rooms were not welcoming or homely. Room temperatures were frequently cold, and we asked staff to increase these during the inspection. Relatives were complimentary about the recent redecoration which had taken place in communal areas, and hopeful this would be extended to include people's rooms.

Premises and equipment were not adapted to meet people's care needs. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff had not all received sufficient training to ensure people received safe care and support. Checks of staff competency were carried out for some areas of practice, such as medicines. However, other areas of practice were not always assessed by staff who had completed relevant training and had their own competency checked first. There was little evidence of practical safety related training, such as first aid and moving and handling.
- Staff were not always clear about their roles and responsibilities, or how to meet people's needs. Staff said they received training online, although they could not recall what training they had done recently.
- Where people were living with dementia, staff lacked training, understanding and ability to support them. For example, where some people presented as anxious and said they wanted to go home, staff responses were not appropriate or effective.

Staff were not suitably trained or supported to fulfil the requirements of their role. This placed people at risk of harm. This was a breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Most relatives we spoke with felt staff had the necessary skills to meet people's needs. For example, one

relative said, "Yes, they do – they are very patient. All the [staff] have approached me as to how I would like them to support my [relative]. They are supportive to me and my [relative], we work as a team." Some relatives however, lacked confidence and one relative said, "Some do [have the right skills], others don't. I saw two [staff] doing some training in the lounge – they were going through a book together."

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.

● People were not always consulted and supported to make choices for themselves. Staff were not always clear about people's rights or the principles of the MCA to ensure these were upheld. Staff made everyday decisions for people. For example, they guided people to seating, and put activities on tables in front of people, without any discussion.
● DoLS authorisations were in place, although staff did not always know if there were any conditions in place for individuals.
● People's mental capacity was inconsistently regarded and recorded, with limited evidence of best interest decision making where necessary.

We recommended staff consistently involve and include people in decision making, in line with the principles of the MCA.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were not assessed and delivered in line with good practice guidance. This is reported under the 'well led' section of this report.
● Care records were blank in places and information about risk was not accurately assessed or recorded. Staff did not always deliver care in line with people's needs. For example, where people needed support with pressure relief or continence care, this was not consistently managed.
● Staff lacked understanding of people's needs and therefore did not effectively support them with their choices. Staff were not always able to describe the level of support individual needed, such as how frequently a person needed repositioning, or their abilities to see, hear and communicate. Staff provided care for people, rather than consulting with them. For example, directing them where to sit, placing clothing protectors at mealtimes and presenting tabletop activities without discussion.
●The provider used a dependency tool to determine people's levels of dependency and staffing. However, this was not effective because information about people's needs was not accurately assessed or documented.

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

● People received enough to eat and drink; staff offered drinks and snacks at intervals throughout the day. Where people were frail and at risk of losing weight, information about their dietary intake was not always recorded. Where records were kept for some people, these were not effectively detailed. For example, 'ate all/half' was recorded, but no indication of what or how much was eaten.
● There was variable knowledge amongst the staff team about people's dietary needs or where they needed additional support. One person who was at risk of weight loss had slept through mealtime and there was little attempt made to encourage them to eat and drink.
● Information was displayed in the kitchen where people needed modified textured meals, although this did not include all dietary requirements.
● People enjoyed the meals in the home. One person said, "Oh I like the dinners." Another person said, "I usually like the food and it's alright most days." One relative told us, "There are nice meals from what I've seen." Another relative told us the cook had made a 'chip butty' because their relative did not want what was available.
● Where people needed support with their meals, staff tried hard to assist them as appropriate, although they had to divide their time between other people who also needed help. People were not always offered sufficient choices. For example, it was 'fish Friday' when we visited, and there was no second choice offered.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● There was evidence of routine healthcare, for example GP and local healthcare team support. However, it was not always clear where non-routine concerns had been escalated to other professionals. For example, one person's records showed they had refused their medicines for seven days; staff said this had been referred to the person's GP, but there was no record of this having been done
● Staff knew who to make referrals to if people needed more specialist support, such as speech and language therapists and community nurse teams.
● People's care records showed they had input from other professionals in relation to mental health, feet and eye care where necessary.

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 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.

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

- The poor staffing levels and inconsistent delivery of care, meant people were not always supported or their individual needs met.
- Staff told us they tried their best to be kind and caring and we saw staff approached people with a calm, patient and caring manner.
- Some disrespectful terminology was used amongst staff in people's presence, such as referring people as 'double ups' and 'feeds' where people needed staff support. Whilst it is likely this language was used without ill intent, it was indicative of staff needing further training.
- Relatives told us staff were friendly, kind, caring and welcoming. One relative said, "They are so lovely to everyone, and I get offered a drink." Another relative said, "I'm greeted with a smiling face."

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

- People were not consulted and involved as partners in their care, either informally and formally, such as through residents' meetings. Staff did not always ask people about their day to day preferences, or their longer-term goals and wishes.
- There was a lack of understanding of how individual people communicated so that staff understood their views, preferences, wishes and choices. One person's care record said they could verbally communicate, yet staff did not attempt to speak with the person, only about them. One member of staff said, "We just do everything for [person] because they don't speak, we care for them as we would a baby."
- Staff asked people their choice of food at mealtimes, but some people could not retain information easily and they were not supported with visual cues, such as seeing the food on offer.
- One relative we spoke with said, "They do ask my [relative] what they want, I think they have some choice about how their care is done. The staff seem to know my [relative] well and how they like things. They're very patient."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always promoted.
- People's rooms did not all have window coverings, and some people's beds were unmade. People's personal items of clothing were not always stored thoughtfully.
- People's personal appearance was considered and they were supported to be suitably dressed. However, there was a lack of attention given to people's continence needs due to compromised staffing levels. As a result, some people were incontinent before staff were able to support them.

● There was a lack of care for people's teeth and mouths. People had toothbrushes but it was evident these had not been used for cleaning their teeth. For example, several toothbrushes we saw were dry and ingrained with dirt, debris and hairs.

All of the above demonstrates people did not receive person-centred care that met their needs and reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people were able to mobilise, this was encouraged. Staff encouraged people to take their time and move around at their own pace."

Inadequate

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 inadequate. This meant care was not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans and records showed people's needs and preferences, although recording was inconsistent and information was not always known by staff.
- There was a lack of person-centred care and people's choices in how they spent their time were not considered. Activities were not meaningful to people and there was a lack of participation. For example, there were table-top items for people to use, such as small building bricks, colouring books and pens, a magazine and an abacus. There was no evidence of people being asked what they would like to do, and people sat passively without engaging.
- One person we spoke with said, "I'm bored. This [abacus] is for children and I'm a grown adult. There's nothing to do in this place." Relatives gave mixed views about activities. One relative said, "I'd like more activities that my [relative] can do like baking rather than just sitting around all day." Another relative said the items on the tables 'reminded them of a pre-school' but said these 'provided a distraction' for people.

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 aware of their responsibilities to meet people's communication needs and they stated this in their PIR. However, communication with people was not done in individually accessible ways.
- Care records contained details of how people preferred to communicate. For example, if they had difficulty with their hearing or their eyesight. However, not all staff were aware of such difficulties and there was no evidence of adaptations made to support people to communicate more easily.
- In some people's care records we saw they needed large print to be made available so they could see information easily. We did not see evidence of large print in use.

People did not receive person-centred care that met their needs and reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- We received mixed views from people and their relatives; some said they did not have any reason to complain and they were happy with the quality of care. Comments included, "[Manager] knows my [relative]

is my main priority and [they] take me seriously. I only have to ask once and it's sorted" and "[Manager] is approachable and will always give me a call back."

● Other relatives however, said they were less than happy, particularly during recent months as standards had declined. One relative told us, "I raised an issue, and it remains unresolved as the carer has left. It's got to the point that every time we go, we have to say this isn't right, that isn't right. It's very wearing for us."

● There was no evidence to show how care had improved in response to complaints or concerns. A public review website contained negative feedback, as well as recent concerns raised with the manager. The issues that had been raised in these concerns were evident at this inspection. This is reported under the 'well led' section of this report. We recommend the provider seeks and acts on feedback and uses this information to improve the service.

End of life care and support

● Care records contained some practical information about end of life, although there was little evidence of person-centred discussion around end of life care wishes.

● Staff had not received training in people's end of life care and support.

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.

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

- There was a lack of oversight from the provider to demonstrate quality assurance and ensure received safe care.
- The manager did not have sufficient understanding of the risks in the service or how to identify and address any shortfalls. They lacked specific knowledge of matters relating to adult social care and as such were unable to identify or fully understand the priorities for improvement. For example, they told us they completed quality checks on staff practice, but they had not had the relevant training.
- There were no robust and regular quality audits. Audits which were completed, such as for people's care plans, did not always highlight changes to people's needs and 'nc' (no changes) was recorded. Medicines audits did not identify shortfalls in record keeping and balance checks, as highlighted at this inspection.
- The manager completed safety walk rounds of the premises and highlighted some areas to improve. However, these did not include the hazards identified during visits made by the local authority contracts team, or this inspection. Where the manager had identified some matters to be addressed, these were re-occurring in subsequent checks which meant the checks were not effective in driving improvement.
- Records were not adequately maintained for monitoring the quality of people's care delivery, or for internal communication such as handovers and provider meetings.

Systems were not robust enough 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 breach of regulation 17(1) 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; Working in partnership with others

- The provider did not sufficiently engage and involve people using the service.
- There was no evidence of meaningful consultation with people, or any newsletters or surveys having been sent to people and their relatives. People and relatives told us they were not routinely consulted or asked their views about their experiences of using the care service, or invited to any meetings.
- One relative said, "I've never had an email about what's going on. Today was the first time in 3 months they had been in contact with me to tell me that [CQC] would be phoning."
- One relative said there was a lack of partnership working with families. They told us, "They are not doing their best, we are not told what is going on and have lost faith in the home."

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

● The culture in the service was not open and transparent. Staff did not feel confident if they raised issues these would be addressed. Most relatives told us communication with management was poor and if they wanted information, they had to ask for it. Where people and relatives raised concerns about the service, they did not always feel they were responded to.

There were no systems to encourage, seek out and act on feedback with which to improve the quality of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was aware of their duty of candour. The manager told us they were trying to develop an open and transparent culture, and use opportunities from the inspection process to learn and improve the service.
● There had been some meetings with the local authority commissioning team to address shortfalls in people's care and support, and the provider was working closely with them to try to identify more clearly the priorities to improve the service. They said they were keen to address all of the issues raised and work collaboratively to drive improvement.

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 did not receive person-centred care that met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems for safeguarding people were not robust enough to ensure people were protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not adapted to meet people's care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff

deployed to meet people's care needs.

Staff were not suitably trained or supported to fulfil the requirements of their role.