Only Care (Blackwell) Limited

Blackwell Care Centre

Inspection report

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Date of inspection visit:
24 October 2023
26 October 2023

Date of publication:
13 December 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Blackwell Care Centre is a residential and nursing home providing personal and nursing care to up to 49 people accommodated across 2 floors of this purpose-built care home. The service provides support to younger and older people, people with a physical disability and people with a sensory impairment. At the time of our inspection there were 42 people using the service.

People's experience of using this service and what we found
The service was not always safe. Staff did not always put their training into practice when supporting people. Accidents and incidents were not always reported. Medicines were not consistently managed safely.

There were not enough staff at night to meet people's needs safely. Staff felt they needed more time to spend with people beyond task-focussed personal and nursing care. The provider had not consistently ensured staff had regular checks on their skills, competency, and confidence to carry out personal or nursing care.

People were not always 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.

People were not consistently involved in planning and reviewing their care, particularly where they were less able to communicate their needs. People were not consistently supported to take part in activities that were relevant or meaningful to them.

The service was not well led. The provider had not ensured they had systems and processes in place to robustly assess, monitor and improve the quality and safety of the service. People were placed at risk because issues with the quality of care were not consistently identified. There were missed opportunities for learning and improvement of care.

Staff understood how to recognise and report concerns or abuse. The service was kept clean and people were protected from the risk of an acquired health infection. People told us the quality and variety of the food was generally good. People had access to GP, dentist services and other healthcare professionals.

People and relatives spoke positively about the staff who provided support. They felt all staff were kind, caring and hard-working. The management team and staff team understood their roles and were open and honest during our inspection.

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 under the previous provider was outstanding (published on 22 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received about how personal and nursing care was being planned and delivered. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Blackwell Care Centre

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 first day of inspection was carried out by 2 inspectors and an Expert by Experience. The second day was carried out by 1 inspector. 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
Blackwell Care Centre 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. Blackwell Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. A new manager had been in post since the end of June 2023 and had applied to register with us. 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 since the last inspection. We sought feedback from the local authority. 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 of this information to plan our inspection.

During the inspection
During the inspection we spoke with 3 people who used the service and 4 relatives. We observed how care and support was given generally. We spoke with 10 clinical and non-clinical staff involved in the direct delivery of personal and nursing care, and with 5 staff involved in other aspects of the day to day running of the service. We also spoke with the manager. We looked at a range of records including 4 people's care records and how medicines were managed for people. We also looked at staff training, recruitment, and the provider's quality auditing system. During the inspection visit we asked the manager to give us additional evidence about how the service was managed, which they sent to us.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff did not always put their training into practice when supporting people. We saw 3 occasions where people were supported in ways which put them at risk. This included supporting a person to walk in a way which put both the person and staff member at risk of injury. We spoke with the manager about this and they took immediate steps to address this.
- Accidents and incidents were not always reported, which meant the provider was not consistently able to use this information to identify trends and to prevent reoccurrences. For example, medicine issues that staff told us about were not reported, so the provider could not have oversight of how safely medicines were managed. There was a risk that medicine errors would continue with no action to reduce the risk of people not taking medicines as prescribed.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's needs were assessed, and any risks associated with their personal care and environment documented. Staff knew about risks associated with people's health conditions and understood how to provide care which kept people safe.
- Risks associated with the service environment were assessed and mitigated. The provider had clear systems in place to ensure regular checks on all aspects of the environment. We looked at a sample of these checks, and could see where good practice was noted, and where areas for improvement were identified.
- There were plans in place to guide staff in what to do in an emergency, and staff knew what the plans were. The provider also had a business continuity plan in place, setting out how the service would continue to run well in the event of a major incident, such as a widespread infection outbreak.

Using medicines safely

- Medicines were not consistently managed safely.
- Guidance for the use and effectiveness of "as and when" medicines (known as PRN) was not consistently in place. This had been identified as an issue by the local authority in their September 2023 audit. One person did not have PRN guidance in place. Although the person was given the medicine when staff identified this was needed, there was no record of the medicine's effect. This meant there was a risk that the medicine could be ineffective or potentially over-sedating the person.
- Two staff said on occasions, they found medication tablets discarded. As they did not know whose medicines these were, on each occasion they told us they returned to the appropriate staff member in charge of medicines for secure disposal. This meant staff could not be sure people were taking their

medicine as prescribed. There was also a risk that other people would take medicine that was not intended for them.
● Some medicines were not stored at the correct temperature. Staff told and showed us 1 person's prescribed nutritional supplements stored in an ensuite toilet which was not temperature monitored. The manufacturer's recommended storage temperature was between 5-25 degrees Celsius. Staff confirmed the room temperature was warm and not monitored, so they could not be assured the supplements would be effective.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received training about managing medicines safely and had their competency assessed.
● Each person's medicines records had key information about allergies and how people liked to be given their medicines.

Staffing and recruitment
● There were not enough staff at night to meet people's needs safely. We reviewed the number of staff on shift at night and the provider's emergency evacuation plan. We also considered the mobility and support needs of people, and determined there were not enough staff at night.
● Staff expressed concerns about their ability to move people through the building to a place of safety in a timely way if there was an emergency. One staff member said, "We couldn't get everyone out if we needed to in the event of an emergency [in reference to night staffing levels]."
● The provider had not made sufficient staff available to review and update people's care records in preparation for a new electronic care planning system. One staff member reported coming in on their time off to work on care plans and associated records. Staff felt they were not consistently allocated protected time to do this work, and that the timescales for the new electronic care planning system were not realistic. The provider had assured the local authority that everyone's care documentation was ready to 'go live' on the new system by 9 October 2023, but this was still a work in progress on our inspection, indicating that staff were not allocated the time needed to achieve this.

Due to a lack of staff at night, people were placed at risk of harm. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, relatives and staff felt there were enough nurses and care staff available during the day. Staff rotas and what we saw supported this.
● Staff told us, and records showed the provider undertook pre-employment checks, to help ensure prospective staff were suitable to care for people. This included employment and character references and disclosure and barring service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This all ensured staff were of good character and were fit to carry out their work.

Preventing and controlling infection
● The service was kept clean and people were protected from the risk of an acquired health infection. People and relatives commented positively about cleanliness.
● Staff understood and followed infection control procedures and had regular spot-checks on their practice. The management team and staff carried out regular checks in relation to cleanliness, infection prevention and control to ensure this was effective. This ensured risks from an acquired health infection were minimised.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection, and the provider was admitting people safely to the service. The provider was using PPE effectively and safely and was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restrictions on people welcoming visitors to their home.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives generally felt the service was safe.
● Staff understood how to recognise and report concerns or abuse. Staff received training in safeguarding and felt confident to raise concerns.
● The manager reported any allegations or abuse to the local authority safeguarding team. The provider had policies on safeguarding people from the risk of abuse and whistleblowing, and staff knew how to follow these.

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.

Staff support: induction, training, skills and experience

- The provider had not consistently ensured staff had regular checks on their skills, competency, and confidence to carry out personal or nursing care. Staff told us it was important the skills they learnt in training were put into practice correctly, and they had not always had these checks. This meant people were at risk from receiving care from staff who did not always follow the training they received. The manager was in the process of addressing this, but prior to them starting in June 2023, the provider was not able to evidence staff had these checks.

This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives felt the staff team had the skills to provide personal and nursing care.
- Staff told us they had an induction when they started work which included shadowing more experienced staff and being introduced to people before providing care and support. Staff we spoke with had good knowledge of people's needs and told us they felt able to ask for extra training and support when needed.
- There was a programme of training the provider expected staff to do. Training was provided online or in person. Training topics included safeguarding, moving and handling, and nutrition and hydration.

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 not ensured staff understood the principles of the MCA, including how to support people to make their own decisions, and how to proceed if the person lacked capacity for a particular decision.

● Records of assessments of capacity did not consistently document the views of people or relatives, or clearly state what decision the person was being asked to make. There was no information about how choices had been presented to people in ways they could understand.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people.

Supporting people to eat and drink enough to maintain a balanced diet
● Most of the staff involved in delivering care and supporting people in the preparation or eating of food had not done any training on texture modified diets. These diets are advised for people who have difficulty swallowing, following a specialist assessment. Without the correct texture of food and drink, people can be at risk of choking.
● Several staff expressed concerns that for some people breakfast time was too close to lunchtime. Where some people chose to have a later breakfast, there was little flexibility in having their lunch meal later than everyone else. Staff confirmed that lunch could be kept heated for 45 minutes after cooking, but after that, not all meals could be safely chilled and reheated for later.
● People told us the quality and variety of the food was generally good. People told us and records showed there was a varied menu, with options available for people with specific dietary requirements. Where people expressed views about wanting different food options, their preferences were usually met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Assessment of people's needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had access to GP, dentist services and other healthcare professionals. Relatives said staff contacted them if their family member needed external healthcare services. Care records showed staff regularly contacted health professionals for advice if they were concerned about people's well-being.

Adapting service, design, decoration to meet people's needs
● The provider had taken steps to ensure the environment was suitable for people's needs, and there were adaptations for people with mobility needs. People were encouraged to make choices about decorating their personal space, and their bedrooms were personalised.
● Bathing and shower facilities were designed to be accessible for everyone. This meant people were able to make choices about their personal care and promoted independence in bathing and showering.

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.

Supporting people to express their views and be involved in making decisions about their care
- People were not consistently involved in reviews of their care, particularly where they were less able to communicate their needs. Staff said reviews of people's care plans did not always involve people, and records confirmed this. The manager confirmed they were working to improve this.
- People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. The provider had not ensured people who required additional support with communication had their needs met.
- Staff were familiar with people's verbal communication styles and encouraged people to talk about how they wanted to be supported. However, there was no evidence that people were supported with alternative methods of communication to enable them to express their views and feelings about the care and support they received.

Ensuring people are well treated and supported; respecting equality and diversity
- People and relatives spoke positively about the staff who provided support, and felt all staff were kind, caring and hard-working. One relative said, "They [staff] really care about people."
- Staff felt they needed more time to spend with people beyond task-focussed personal and nursing care. One member of staff commented that they felt people would have fewer episodes of anxiety or feel less isolated if staff were able to spend time supporting their emotional well-being.
- Staff clearly knew people well and understood when to offer support and reassurance. We saw lots of kind and thoughtful interactions between people and staff.

Respecting and promoting people's privacy, dignity and independence
- People said staff always treated them with respect, and relatives confirmed this. This included respecting privacy by knocking on doors before entering, and ensuring intimate personal care was done with dignity. Staff had a good understanding of dignity in care and had training in this.
- People were supported to spend private time by themselves or with family and friends. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting.
- Staff respected people's right to confidentiality. Staff understood when it was appropriate to share information about people's care. Staff did not discuss people's personal matters in front of others, and where necessary, had conversations about care in private. Staff understood when it was appropriate to share information about people's care. Records relating to people's care were stored securely.

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 outstanding. 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 consistently involved in planning and reviewing their care. Staff told us and we saw, people were supported to express their opinions about their daily lives, but this was not consistently evidenced in care records.
- People who needed alternative communication methods to help them make decisions and express choices did not get this. We identified people who would potentially benefit from additional support for communication. Staff confirmed people did not always have assessment of their communication needs, or support to find communication methods that could benefit them. This put people at risk of not being able to clearly communicate their needs and wishes and at risk of isolation and being deprived of effective communication.

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 had not taken steps to ensure that people were given information about their care and support in ways which were accessible for them. For example, where people needed additional support in relation to a sensory loss, this had not been considered.

This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 consistently supported to take part in activities that were relevant or meaningful to them.

For example, 1 person had sensory equipment that had previously belonged to another person. There was no assessment in place to identify whether using this equipment was something the person wanted or enjoyed. Staff confirmed this, and said they felt the person would benefit from sensory and other activities that were enjoyable for the person.

- A person was not regularly supported to leave their room. This put the person at risk of isolation and depression. The manager said they would address this concern to look at ways to give the person regular

opportunities for meaningful activities.
● For other people who were more able to take part in group activities, there were opportunities to do things they enjoyed. Relatives spoke positively about the staff who coordinated activities, and said they tried to ensure there was a range of things for people to take part in.

Improving care quality in response to complaints or concerns
● People and relatives knew how to raise concerns or make a complaint. Information about this was available in the home. However, there was no evidence how people with limited or no verbal communication were supported to express their views in order to make a complaint.
● The provider had a policy and process for managing complaints, which was displayed clearly in the home.
● Records showed the provider dealt with complaints and concerns appropriately and took the opportunity to learn lessons and make changes.
● Two relatives told us about issues they raised with the manager, which they felt were then addressed promptly.

End of life care and support
● We looked at how end of life care was planned. People had advance care plans in place which included, where appropriate, records of their wishes about resuscitation. However, people's care records did not consistently record how people had been consulted about their end of life care.
● Staff received training in end of life care.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The service was not well led. The provider's audit systems failed to identify issues we found on this inspection. This meant people were placed at risk because issues with the quality of care were not consistently identified, and there were missed opportunities for learning and improvement of care.
- We identified people at the service who were living with a sensory impairment who did not receive support to meet those needs. The provider's statement of purpose stated they met the needs of people living with a sensory impairment. A statement of purpose is a legally required document that includes a standard set of information about a provider's service, including who the service is for. The provider had not ensured that people with a sensory impairment consistently had those needs assessed or met, or that the staff team had received training the provider felt appropriate to meet these needs.
- There was evidence of a cultural approach to people's care that was not person centred. For example, we saw a rota for set bath or shower days, and 1 person confirmed they had a set bath day. Staff confirmed people had a set day of the week for bathing and clarified that if anyone needed this in between these days they would be supported to maintain their personal hygiene. All staff we spoke with told us they had difficulty providing person-centred care to people in ways which met both their needs and wishes due to staffing levels.

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

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

- The provider had not ensured they had systems and processes in place to robustly assess, monitor and improve the quality and safety of the service.
- The provider's audits of the quality of care were not consistently effective at identifying or rectifying issues. For example, assessments of people's mental capacity were not always carried out or were not in line with the MCA. The audits of care plans had not identified this oversight, leaving people at risk of not having their rights in relation to consent and capacity upheld.
- Issues arising from people not taking their prescribed medication and leaving tablets where others could access them were not reported as incidents. We reviewed all accidents and incidents for 2023 and did not find any records relating to discarded unknown medicines. The provider therefore could not identify themes or patterns relating to these incidents. This put people at continued risk of either not taking their medicines

as prescribed, or inadvertently taking a medicine not intended for them.

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

● The provider was displaying their ratings from the previous inspection, both in the service and on their website, as required by 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; Continuous learning and improving care; Working in partnership with others
● The provider had not ensured that feedback from a local authority quality audit in April 2023 had been used to improve the quality of personal and nursing care. When the local authority and ICB (Integrated Care Board) visited again in September 2023, there were issues outstanding where the provider had not taken action to improve. An ICB is an NHS organisation responsible for planning to meet local health needs.
● Staff told us they did not feel confident their concerns or ideas for improving care would be acted on in the past. Staff described communication as needing improvement, with several staff describing inconsistent ways of communicating key changes to the quality of the service.
● Whilst staff felt able to raise concerns, they did not feel the provider's systems and processes used this feedback to improve the quality of personal and nursing care, and we saw no evidence that these staff concerns were given appropriate weight when considering service improvements. This had an impact on both the quality of care and staff well-being.

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

● Feedback from health professionals was positive, with 2 commenting that staff were knowledgeable about people's needs and sought advice and support in a timely way.

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 provider had systems in place to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements providers of services must follow when things go wrong with care and treatment.
● The management team and staff team understood their roles and were open and honest during our inspection.
● The provider was aware of the requirement to notify the CQC of certain incidents, and our records showed that these notifications were sent in as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not consistently person-centred or designed and reviewed with them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured staff understood the principles of the MCA, and assessments of capacity did not consistently document the views of people or relatives, or clearly state what decision the person was being asked to make. There was no information about how choices had been presented to people in ways they could understand.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always supported safely. Medicines were not always managed safely. Accidents and incidents were not always reported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) Due to a lack of staff at night, people were placed at risk of harm. 18 (2) The provider had not consistently

ensured staff had regular checks on their skills, competency, and confidence to carry out personal or nursing care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service was not well led. The provider's audit systems failed to identify issues we found on this inspection. The provider had not ensured they had systems and processes in place to robustly assess, monitor and improve the quality and safety of the service. The provider had not ensured that feedback was used to help evaluate and improve the quality of personal and nursing care.

The enforcement action we took:

CQC served the provider with a warning notice for this breach.