Four Seasons (Evedale) Limited

Charnwood

Inspection report

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Date of inspection visit:
04 November 2019
05 November 2019

Date of publication:
30 December 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Charnwood is a care home providing personal and nursing care to people. The service can support up to 88 people. At the time of the inspection 39 people were using the service. The service is split into two buildings 'Charnwood House' and 'Charnwood Court'. Both were considered at the inspection.

People's experience of using this service and what we found
People's care needs were assessed appropriately. However, they did not always receive the care needed to protect them from developing pressure wounds or to reduce their risk of injuries caused by falling over. When incidents happened, the provider dealt with them appropriately, but did not always review them in enough detail to identify ways in which the incident might have been prevented. The provider's quality monitoring systems were not always effective at ensuring people received the care support they required. That meant some people may have been at increased risk of harm. The provider recognised they needed to improve and had put in place additional support for the registered manager to continue the improvements in the service provided to people.

Discussions about people's end of life preferences and plans had not always taken place with people or their relatives; and that meant care staff might not always know the person's wishes at that important time. The care home did not always provide people with information in ways they could access and understand. For example, menu boards were not easy for people to see.

People were supported to eat and drink enough, and they had a varied menu to choose from. Arrangements were in place to monitor people's weight, but there were not always suitable arrangements in place to ensure people drank enough to avoid potential dehydration.
People who smoked were able to do so outside the care home, but there was no suitable smoking shelter to protect people from the weather.

The care home environment was well maintained and safe, and people were supported by enough staff to meet their care needs. The service sometimes used agency care staff to help cover for staff vacancies and absences. The service aimed to only use regular agency staff, but not all agency staff had received a formal induction into the safety systems, and people's support needs, at the service.

People lived in a care home which was clean and were supported by staff who understood about hygiene and the ways in which infections could be prevented and controlled. Care staff understood how to protect people from potential abuse and knew how to raise the alarm if they had any concerns about the support people received. People received their prescribed medicines from qualified nurses, and the provider's arrangements for the management of medicines in the care home were well organised and safe.

People's privacy and dignity was maintained, and they were supported by staff who treated them with kindness and compassion. People were encouraged to take part in planning their own care where they had the capacity to do so. People were offered a range of activities they could choose to take part in, and the provider employed an activity co-ordinator, and volunteers, to help people join in.

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
At the previous inspection this service was rated as inadequate (published 30 August 2019) and there were multiple breaches of regulations.
At that previous inspection, continuing breaches of legal requirements were found in respect of Regulation 12 (Safe care and treatment) and Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We also identified the provider had not notified us of events that had occurred at the service, this is a legal requirement, so we can monitor the safety of a service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the previous inspection, we issued the provider with two warning notices because of those breaches of Regulation 12 and Regulation 17. The warning notices told the provider the improvements that were required and the timescale by which the improvements should be achieved.

This service had been rated inadequate for the last three consecutive inspections and had been in Special Measures since 12 February 2019. During this inspection the provider demonstrated some improvements have been made, but the provider was still in breach of regulations.
However, the service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report.

Since the inspection the provider has acted effectively to reduce some of the risks we identified. For example, in respect of protecting people from the risk of falls.

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

Enforcement
At this inspection, we identified breaches in relation to; how the provider acts to reduce people's risk of developing pressure wounds or being injured by falling, and the leadership and governance processes the provider has in place to ensure those actions happen and are effective.

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

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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?

Good

The service was 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.

Charnwood

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors and a specialist nurse advisor.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection visit took place on 4 November 2019 and was unannounced. We returned, announced, on 5 November 2019 to complete the inspection.

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 had worked with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and one relative about their experience of the care

provided. We spoke with 13 members of staff including the regional manager, resident experience support managers, registered manager, nursing staff, care workers, catering staff and maintenance worker. We observed staff interactions with people throughout the inspection.
We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and details relating to incidents that had occurred at the care home. We reviewed an infection prevention and control audit report carried out by an external health care professional.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has now improved 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

At our last inspection the provider had failed to manage the risks people faced and there was a lack of cleanliness in parts of the care home. This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been some improvements, but not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● People were not always protected from the risk of developing pressure wounds. Some people received care which was not in line with their care plan. For example, one person had a pressure ulcer and was not supported to reposition in line with the guidance in their care plan. That meant there was a risk of the person's wound deteriorating further.
● People were not always protected from a risk of falls. For example, one person had a movement sensor in their bedroom, to reduce the risk of them falling. However, this was incorrectly positioned and did not always detect the person moving. That meant the person was at increased risk of falling. This was brought to the registered manager's attention who immediately arranged for the sensor to be re-situated.
● People's risk assessments did not always inform their care plans. For example, one person's need for support with a pressure wound had been re-assessed, but the revised details had not been translated into the care plan to guide staff. That meant people were at increased risk of receiving unsafe care.

The provider failed to ensure that care and treatment was provided in a safe way. Arrangements were not always in place to do all that is reasonably practicable to mitigate any assessed risks to the health and safety of service users receiving the care or treatment. This placed people at risk of harm. The provider's failure to provide safe care and treatment was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were protected from risks associated with the environment. Routine health and safety checks ensured the care home environment was kept safe. Fire risk assessments, staff training, and evacuation procedures were in place. This helped to ensure people's safety in an emergency.

Learning lessons when things go wrong
● Opportunities to learn from accidents and incidents had been missed. Incident reviews were not always effective, and action to identify preventative measures was not always carried out. For example, the reasons

why a person may have developed a pressure wound was not always considered in enough detail to identify ways in which recurrence could be prevented. This meant some people were at increased risk of recurrent pressure wounds.

Staffing and recruitment

● Staff rota records were not accurate. We found no evidence the care home had operated with unsafe numbers of care staff on duty; but the rota records did not always show how many staff members were at work, and records did not always confirm that enough staff were on duty to support people's care needs.

● Agency care staff were not always safely inducted into the care home. That increased the likelihood of agency staff not understanding the safety systems, or how people needed to be supported. The registered manager told us they would ensure induction training was provided for all agency staff used.

● Staff were recruited safely. The provider had an effective recruitment policy and procedure in place. Staff pre-employment checks had been carried out. However, not all staff records included a full work history. The registered manager told us they would obtain full employment history records for all staff. This helps to ensure people employed as staff are suitable to work with vulnerable people.

● There was a risk staff may provide unsafe support due to tiredness. A senior care staff member occasionally worked for 24 consecutive hours. We found no evidence of a direct impact on the care people received, but there was an increased potential for errors caused by staff working such long hours.

● People were supported by enough staff to meet their care needs. The registered manager used a dependency assessment tool to calculate the numbers of care staff and nurses required to support people safely; and told us staffing levels had been increased since the previous inspection.

Preventing and controlling infection

● People were protected from the risk of infection. Hygiene in the care home had improved since the previous inspection. People's rooms, bathrooms and communal areas were generally clean.

● Staff understood how to prevent and control the spread of infections. Most staff had completed infection control training. Personal protective equipment, such as disposable gloves and aprons, was readily available throughout the service and used by care staff. This protects people, and care staff, from acquiring infections.

Using medicines safely

● People received their medicines as required and medicine management systems were safe. The provider followed safe procedures for the receipt, storage, administration and disposal of medicines. Monthly medicine audits were carried out by the provider's management team. This helped ensure medicine management was safe and the likelihood for error reduced.

● Prescribed medicine was administered, to people who required it, by registered nurses. The nursing staff were supported, by the provider, to maintain their professional registration with the Nursing and Midwifery Council. That helped to ensure people's medicine and health care needs were met by appropriately qualified staff.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Staff had received safeguarding training, were aware of the safeguarding procedure, and knew how to use it. There were safeguarding adults' policies in place, which staff had access to.

● Incidents were notified to the relevant authorities. The registered manager understood their responsibilities and had systems in place to record incidents at the care home. This helped keep people safe from the risk of abuse.

Requires Improvement

Is the service effective?

Our findings

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

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

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

- People were at risk of receiving inconsistent support. Care plans did not always reflect people's current care needs. This potentially meant people would not receive care in the way they needed it.
- People's individual risks were assessed. Care plans used universally recognised assessment tools, so staff could identify the individual risks people faced. For example, if a person was at risk of losing weight, their malnutrition risk was calculated and advice from a health care professional obtained.

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

- There was a risk people may not have enough to drink. Staff regularly recorded when people had drinks, but reviews were not always carried out to see if the total amount drunk by individuals was enough to prevent dehydration. This meant there was a risk some people's health may deteriorate.
- People were supported to eat safely and maintain a balanced diet. For example, where people required support to prevent potential choking, kitchen and care staff had received training on how to support people who required modified diets.
- Staff knew what people's favourite food was. Care staff had a good knowledge of people's food preferences and their weight was monitored appropriately. This helped ensure people were eating enough.
- People were offered a variety of food and drink each day. Feedback from people, about the food, was varied. One person told us, "Lunch isn't always very clever, but it is what it is." Another person told us, "We get different things each day, and it's nice. I like the food." Alternative menu items were readily available.

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

- Staff were not trained in supporting oral healthcare needs. A member of care staff told us, "I haven't had any specific training about that here, we just support people with personal care, so I guess it comes under that." Support to maintain oral health is important because of the potential effect on people's general health, wellbeing and dignity.
- Opportunities to expand care staff training were sometimes missed. A community health care professional told us, "The care home has turned down offers of training over the last couple of years. We offered them specialist training in the types of issues which older people with dementia and complex care needs have. But they didn't take up the offer."
- People were supported to access healthcare services. The service had links with GPs, district nurses and other primary health care professionals.

Staff support: induction, training, skills and experience

● Staff helped people to move safely. The provider carried out regular observations of care staff competency to complete moving and handling tasks. We saw care staff supporting people to mobilise safely.
● People were supported by staff who were appropriately trained. The provider had a training plan and arrangements were in place to ensure care staff were kept up to date with essential training.
● New care staff completed induction training, which included working alongside experienced care staff. Care staff told us they received the training needed to meet people's individual needs. We observed care staff using their skills to support people effectively and sensitively.
● There was effective communication within the care team. Care staff told us they had regular handover sessions, team meetings and supervision meetings.

Adapting service, design, decoration to meet people's needs
● People who smoked were not provided with a suitable outdoor smoking shelter. A person told us, "It gets a bit drafty sometimes, especially in the winter. Staff can't smoke with me, they have to go around the corner out of sight. They have their own shelter". This was brought to the registered manager's attention who told us they would consider installing a suitable shelter, accessible for people using wheelchairs.
● Some people had personalised their bedrooms. However, the numbered bedroom doors had few other visual identifying characteristics which would support people with dementia to orientate themselves.
● Improvements to the security of the building had been made following an incident where a vulnerable person had left the building without being observed by care staff.
● The general facilities at the service met people's basic needs. There were enough bathrooms and toilets available, and there was a lift for people whose bedrooms were on the upper floor.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found they were.

● People's rights under the MCA were respected. People's care plans contained details of any DoLS authorisations in place and any conditions associated with them. This meant support for people, who lacked the ability to consent, was provided in their best interests.
● Mental capacity assessments were in place. The care plans, reviewed during the inspection, included mental capacity assessments and details of best interest decisions. This helped ensure any decisions taken on people's behalf were in their best interest.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were well treated by the care staff. During daily care tasks, some people living at the service experienced confusion. We saw staff guided people who became confused in a compassionate way. This meant staff treated people with compassion and kindness.,
- Staff were caring. One relative told us, "The carers are fantastic. They are really busy, but they take the time to chat with people." A person told us, "It's good here. I've been here for two years now, and I am content with things here." This meant people were happy with the way staff supported them.
- People's individual characteristics were understood. Most staff had received equality and diversity training. The provider's equality, diversity and human rights policy stated how the care home supported people, and staff, from diverse backgrounds. This helped to ensure support was provided in keeping with people's individual needs.
- Peoples' disability support needs were met appropriately by the provider. The registered manager assessed people's support needs as part of the assessment carried out prior to people moving into the care home. This helped ensure a person's equality and diversity needs were considered when planning their support.

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

- People were involved in deciding their own care plans, where they had the capacity to do so. Best interest processes were in place where people lacked capacity to make those decisions.
- Care staff supported people to make everyday choices about their care and support; for example, about what clothes they wanted to wear and how they wanted to spend their time. This enabled people to be involved in making decisions about their care.
- Care plans described how people communicated. Staff had a good knowledge of people's communication needs and communicated appropriately with them.

Respecting and promoting people's privacy, dignity and independence

- People were treated with respect. When staff spoke to people, we saw they addressed them in the way the person preferred.
- People's privacy was respected. We observed staff knocked on doors before entering people's private rooms.
- People's independence was promoted. A care staff member told us, "We let people choose things for themselves. Like showering, we let people wash themselves if they can do it, and then they choose what they want to wear." This meant people were supported to maintain their skills where possible.

● People were treated with dignity. Staff supported people to dress appropriately and supported them to maintain their personal hygiene when required. A relative told us, "Staff are really good at making sure Mum is dressed well and the way she wants it." When people required personal care support we saw it was provided in a timely and discreet way.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

● People's care was not always responsive to their needs. For example, the provider had replaced the carpet in a person's bedroom with a laminate flooring to enable staff to clean the floor more easily; but that had increased the risk of the person slipping over. This was discussed with the registered manager who arranged for the person to move into a bedroom which had carpet fitted, and was closer to the lounge area, so staff could attend to the person more quickly if needed.

● People's care plans contained personalised information. Care plans were developed when people first moved in. This helped ensure staff had access to information about people's needs.

● People were supported by staff who knew their routines and preferences. Some people had been supported to decorate their private rooms in personalised ways. For example, a relative told us, "Mum's room is really personalised. She always has fresh flowers." This helped people to express their individuality.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The requirements of the AIS were not always met. Information was not always readily available to people in formats that were accessible to them. For example, menus were not always accessible. Care staff asked people what they would like from the menu, but people could not always see the menu for themselves.

● The registered manager was not fully aware of the requirements of the AIS, and we discussed that with them. They told us they would review how they present information to people, so it was more accessible.

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 supported to maintain contact with their relatives where appropriate. People contacted their relatives using the care home phone if they wished. Supporting people to maintain contact with their relatives is important and helps prevent social isolation.

● People took part in varied activities at the care home. The provider employed an activity co-ordinator, and volunteers also supported people to take part in activities. This helped ensure people could take part in activities that they were interested in.

Improving care quality in response to complaints or concerns

● People were able to tell the provider about their concerns and complaints. The provider had a complaint policy in place and details of how to make a complaint, or give feedback on the service, were on display. This meant people had the opportunity to raise any concerns formally and receive a response.
● Following our previous inspection, and subsequent quality audits carried out by the local authorities, the provider was continuing to make improvements in response to concerns that had been raised with them.

End of life care and support
● People did not always have end of life plans in place. The service had not always explored people's preferences and choices, and that meant care staff may not always know the person's wishes at that important time.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has improved 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

At our last inspection, the provider had failed to ensure that systems and processes, designed to identify shortfalls and to improve the quality and safety of care, were effective; and people were exposed to potential risk as a result. We had identified shortfalls in record keeping, cleanliness, fire safety and reporting safeguarding concerns to the local authority. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been some improvements, but not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● People did not always achieve good outcomes. For example, the provider's quality audit systems had not identified when some people's pressure wound care plans did not reflect their actual support needs, and some people's care was not provided in line with their care plans. This meant the necessary pressure wound preventative measures had not always been in place, and the provider's management processes had not identified that. The provider's ineffective quality monitoring process potentially meant some people were at increased risk of developing pressure wounds.
● The provider's management systems did not always protect people from falls. For example, the provider had assessed a person was at a high risk of falls. The care plan stated a movement sensor device was required in the person's bedroom; to detect when they tried to stand up. We were told staff sometimes moved the sensor during the night, to prevent it triggering. We were also told the person sometimes unplugged the device themselves. Although this appeared to be widely known to the care staff team, the provider's quality management processes had not identified that issue until it was raised by the inspector. The provider's ineffective management processes potentially meant some people were at an increased risk of injury resulting from falls.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff morale was positive. The registered manager, nurses, and all the staff we spoke with and observed, told us they were committed to providing person centred, high quality care. Staff we spoke with told us they felt supported by the new registered manager. A staff member told us, "It's a good place to work because of the residents. Things are better now from how they were last year."

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

● People were notified when incidents happened. The registered manager understood, and acted on, their duty of candour responsibility by contacting relatives, after incidents involving family members occurred. This ensured relatives were notified of the incident and made aware of the causes and outcome.

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

At our last inspection, the provider had failed to notify the CQC about incidents that occurred at the service. This was a continuing breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● Notifications to the CQC were made when required. The registered manager understood their responsibility for reporting deaths, incidents, injuries and other matters that affected people using the service. Notifying the CQC of these events is important so we are kept informed and can check appropriate action had been taken.

● Staff understood their roles. Care staff, nurses and senior management were aware of their different roles and responsibilities when caring for people, and the registered manager had a good understanding of regulatory requirements.

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

● Peoples views on the service were listened to. The provider carried out satisfaction surveys. Resident and relatives' meetings happened occasionally, with the registered manager. People were invited to attend if they wished and outcomes from those meetings were implemented by the registered manager. That enabled people to shape the support provided by the service.

● The registered manager also obtained the views of people by talking with them while doing 'walk around' checks. This helped ensure the people who used the service were involved.

● People's equality and diversity characteristics were identified during the initial assessment process. These were recorded in each person's care plan, which was available to guide care staff, and was supported by the provider's equality, diversity and human rights policy.

● People could give the provider feedback in different ways. The provider had installed electronic devices to enable relatives, and visitors, to give feedback on the service. However, one relative told us they preferred to tell staff about any issues rather than type them into an electronic device.

Continuous learning and improving care

● The provider had improved the cleanliness and hygiene of the service. The provider had acted to ensure lessons had been learned from previous CQC and infection control reports. This helped to reduce risks for people.

● The provider had committed resources to support improvement. The provider's resident experience support managers had been assisting the registered manager to improve the service following the previous inspection. This showed the provider's commitment to improving the service people received at Charnwood.

Working in partnership with others

● The care team worked in partnership with other agencies. The registered manager and care staff worked in partnership with other professionals, such as GPs and community health services to enable people to receive the care and support they needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that care and treatment was provided in a safe way. Arrangements were not always in place to do all that is reasonably practicable to mitigate any assessed risks to the health and safety of service users receiving the care or treatment. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was a continuing breach of Regulation 17 (Good governance) Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.