Hinckley Care Limited

The Ashton Care Home

Inspection report

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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?	**Inadequate**

Summary of findings

Overall summary

About the service
The Ashton Care Home is a purpose-built residential home providing personal and nursing care to 29 people aged 65 and over at the time of the inspection. The service can support up to 72 people.

The Ashton Care Home is currently using two out of the three floors of the service. People living at the service have their own bedroom with ensuite facilities. There are shared dining and lounge areas on each floor. There is also a hair salon and cinema rooms people are able to access.

People's experience of using this service and what we found
The provider continued to fail to ensure the service was well-led. The management team had undergone further changes but there remained significant shortfalls in governance and oversight at the service. Levels of monitoring such as daily flash meetings, audits and compliance visits were taking place, but had failed to recognise changes needed to be made. Enough improvement had not been made to ensure people received safe care and treatment.

The provider continued to not ensure effective systems were in place to assess and monitor people's needs. Staff did not always have enough information about people's assessed care needs to guide them to safely care for people. The provider did not always ensure medicines were managed safely. The provider also failed to ensure all staff were effectively trained in all aspects of care delivery. This meant people continued to be exposed to unnecessary risk of harm.

The provider continued to fail to fulfil their legal responsibilities. We continued to find breaches of regulation at this inspection. We did not find enough lessons were learned to ensure breaches of regulation were met.

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

People felt staff knew them well and provided care and support to them in a dignified way. We observed caring interactions between staff and people living at the service. People and their relatives spoke highly of the staff and the management team, and felt changes were being made at the service.

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

Rating at last inspection (and update)
The last rating for this service was inadequate (published 10 June 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had still not been made and the provider remained in breach of regulations.

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

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

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicine management, assessment of risks, staff training and governance at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Requires improvement'. The service continues to be placed in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Ashton Care 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 Care Act 2014.

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 inspection was carried out by two inspectors, one specialist advisor and two Experts 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
The Ashton Care Home 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A manager was in post and in the process of applying for registration with CQC.

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. The provider was not asked to complete a provider information return prior to this

inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided and three relatives. We spoke with 15 members of staff including the manager, deputy manager, regional director, unit managers, senior care workers, care workers, kitchen staff, housekeeping and maintenance staff.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at three 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 quality assurance records. We also spoke with seven relatives of people living at the service about their experience of the care provided.

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.

At our last inspection the provider had failed to ensure medicines were managed and administered safely, and to ensure people always received safe care and treatment. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Using medicines safely

● Covert medicine protocols were not in place. Some people required medicine to be concealed in food or drink. This had been authorised by a GP, but there was no guidance from a pharmacist telling staff how to prepare the medicine safely. The unit manager and deputy manager contacted the pharmacist who provided relevant covert medicine protocols and guidance to the service during the onsite inspection visit. We could not find mental capacity assessments or best interest decisions had taken place in relation to covert medicines during inspection, but evidence of this was later provided after the onsite inspection visits.

● Medicine protocols were not always accurate and not always followed. One person had differing information recorded in medicine protocols and care plans about what parameters were safe for their blood glucose levels to be. We found occasions where the person's blood glucose levels were unsafe, but there was no evidence medical assistance had been sought as per the medicine protocol. This meant people may have been placed at risk of harm as staff were not always following the guidance available.

● Medicines were not always administered safely. Some people received pain relief via a transdermal patch. A transdermal patch is applied to a person's skin and medicine is absorbed into the bloodstream. We found there were no checks to ensure the patch was still in place, or that the old patch was removed before the new one was put in place. This meant the risks around people not receiving pain relief, or potentially being exposed to an overdose, were not safely managed. During inspection, changes were made to the EMAR system so these checks could be completed.

● Stock was not always safely managed. During inspection we found some discrepancies in stock for two people. Pain relief medicine for one person, was out of date. The medicine expired in July 2021, and while it had not been administered, systems and checks were not robust or effective at monitoring stocks available when required. We were not assured people always had access to medicines they were prescribed.

● Medicines were not always stored safely. A clinic room was not clean. The worktop where the medicine fridge sat was dirty, as was the sink and surrounding area. Measures to ensure the clinic room was cleaned had been in place since October 2021, but we found they were not robustly completed at the time of inspection. Fridge and room temperatures were not consistently recorded. The service was not following its own medicines policies and procedures, however the manager identified improvements in this area needed

to be made.

The provider had still not made enough improvements to manage risks in relation to medicine management. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed concerns with the management team who implemented an action plan to address this during the inspection.
After inspection the manager shared daily walk round documents which showed clinic rooms were being monitored for cleanliness our inspection.

Assessing risk, safety monitoring and management
● Aspects of some people's essential care needs, and risks had not been assessed. We found some people with pressure wounds did not have treatment plans. Staff were providing care and treatment without clear guidance on how to manage the risk which may have impacted upon how pressure wounds healed.
● Catheter care plans and risk assessments were not always followed. Staff did not always record people's fluid intake and urine output consistently as per their care plans. This meant the opportunity to monitor people and respond to changes/deterioration may not have been dealt with quickly.
● People's hydration needs were not always monitored safely. We found some fluid charts were not always maintained. Two people who were prescribed thickeners to reduce the risk of choking did not have their drinks made in line with their risk assessment. This meant people may have been placed at risk of harm.
● Risks from the environment had not always been identified. People had unrestricted access to areas such as the hair salon and sluices room which contained items that could be harmful.

The providers failure to ensure safe care and treatment and to manage medicines safely was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During inspection the manager worked with the maintenance person to ensure areas of the service were locked and a risk assessment for the hair salon was put in place.
Following inspection, the manager told us health care professionals had been contacted and care plans were updated to be reflective of people's treatment regimes.

● Some improvements had been made to risk assessments. We found people who sometimes became distressed had care plans and risk assessments in place.

Preventing and controlling infection

At our last inspection the provider had failed to ensure staff followed safe procedures to control the risk and spread of COVID-19 and other viruses. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection with regard to infection prevention and control and the provider was no longer in breach of this part of regulation 12.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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.

Staffing and recruitment
● There were enough staff on duty and improvements had been made to the number of staff deployed. We observed staff now had enough time to provide care to people when they needed it. There was no longer a reliance on domestic staff to monitor people in communal areas in the absence of care workers.
● Staff were being recruited. Use of agency staff had reduced and more permanent staff were working at the service. This meant people were cared for by a more consistent team of staff which improved wellbeing.
● Staff were recruited safely. For example, a Disclosure and Barring Service (DBS) check and previous employer references were obtained. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and processes were in place to protect people from abuse and improper abuse. This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Systems and processes were in place to safeguard people. People living at the service and their relatives told us they were safe. One person told us, "Feeling safe is never an issue, I have an alarm around my neck and by my bed and most of time help comes quickly." Relatives felt their family members were safe living at the service.
● Staff understood safeguarding concerns and knew how to report them. The manager understood their responsibility to safeguard people and took steps to do so. The manager also completed detailed reviews of incidents to look for areas of learning which were shared with staff.

Learning lessons when things go wrong
● Day to day lessons were learned. The manager had begun undertaking investigations into incidents when things had gone wrong and identified themes and trends. This learning was then shared with staff to minimise the risk of incidents occurring again.

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

At our last two inspections the provider had failed to deploy sufficient numbers of suitably qualified, competent and experienced staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

Staff support: induction, training, skills and experience

- Whilst there were enough staff deployed, records showed not all staff had completed the required training to provide safe care. For example, records showed only 14 out of 29 staff had completed wound care training. Only 12 out of 33 staff had completed diabetes awareness training. We identified concerns in how people's pressure wounds and diabetes were managed and were therefore not assured people were being cared for safely.
- At our last two inspections staff had not received supervisions or the necessary support needed to keep people safe. At this inspection we found formal supervisions were still not in place.

The provider had not ensured all staff were suitably skilled and trained in all areas of care delivery. This is a continued breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they would ensure all staff would receive the training required and regular supervision. As an interim measure the manager had undertaken a welfare check of all staff.

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

- Whilst people had their care needs assessed in line with good practice, information from assessments was not always recorded in their care plans. For example, one person's diabetes care plan did not fully reflect their treatment plan. This meant staff did not have all the information required to meet their assessed needs safely.
- People had person centred care plans. Care plans detailed people's likes, dislikes and routines which showed people had choice over how their care was provided. A person told us, "Ashton's permanent staff are great; they know me, and I don't have to tell them anything. I don't have to wait for my help and staff know what I can do myself."
- People felt their needs and wishes were listened to. One person told us, "More than anything staff do listen

what I have to say, if I don't feel like eating in the dining room, they will serve my meal in my room."
● People were supported to use technology. People had pressure sensor mats and other technology which helped to keep them safe. This allowed staff to monitor people remotely and promoted people's independence.

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.

● DoLS conditions were not always evidenced as being met. The service could not fully evidence and provide assurances that conditions around social inclusion for example were being met. The manager implemented new documentation for all people who were subject to conditions under DoLS to ensure their needs were met and recorded accurately during the inspection.
● MCAs required improvement. The manager identified, at the start of inspection, that work was required to improve the quality and relevance of MCAs that were in place. Some MCAs were of better quality than others, which meant we could not always be assured best interest decisions had been made appropriately for people who needed it.
● We observed numerous interactions where staff sought people's consent to care.

Staff working with other agencies to provide consistent, effective, timely care
● Improvements had been made to information sharing when people transferred between services. Important information was now readily available in an emergency to relevant agencies when required.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink. There was a choice of meals and people's preferences were sought. Where people requested an alternative meal, this was provided. People were complimentary about the food, and one person told us, "Breakfast is probably the best meal of a day; well-cooked and with lots of items."
● People assessed for needing assistance with their meals were supported by staff. During breakfast and lunch times we observed staff helping people in dining rooms and bedrooms with their meal and throughout the inspection people were provided with regular drinks and snacks.

Supporting people to live healthier lives, access healthcare services and support
● People's changing needs were monitored. Referrals to health care professionals were made if concerns about a person were identified. For example, we saw evidence the GP was contacted when there were concerns about a person losing weight.

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

● People's bedrooms were personalised. We observed bedrooms had photographs and important mementos displayed. The manager had identified improvements were required to the décor of the service, and an improvement plan was in place.
● There were a range of communal areas people could access, for example quiet lounges and cinema rooms.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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 provider failed to ensure staff had the right training and support in place to care safely for people. Records did not evidence people could always receive the care they needed, for example we had concerns about how people's pain levels would be managed and the potential impact of this on their wellbeing.
- Despite these shortfalls we found staff were compassionate and caring. This was confirmed in feedback we received from people and their relatives. We observed numerous interactions between staff and people living at the service which were warm and respectful.
- Staff responded sensitively to people who displayed behaviours that challenged. For example, one person who became verbally distressed was appropriately redirected by staff to talk about a subject of interest to them. This reduced the person's anxiety and those around them from this behaviour.
- Where people required immediate personal care, staff responded promptly and appropriately. One person who required such support during the inspection was guided to their bedroom and spoken to in a discreet manner in front of others to preserve their dignity.

Respecting and promoting people's privacy, dignity and independence

- Staff respected and promoted people's privacy and dignity. One person told us, "What is important for me is that I can feel relaxed with carers who come and help me. It's not easy to accept this kind of help, it is very personal." Relatives told us staff knew their family member well which helped them to provide dignified care.
- People were supported to be independent. One person told us staff had supported them to become more independent as their health and abilities improved. The manager also shared a success story of one person who was supported to maximise their independence and was able to return to their own home following a stay at the service.

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

- People were able to make decisions about their care. People told us they were able to tell staff what they wanted, and their wishes were met. People who were less able to communicate verbally were supported on a one to one basis, and people's relatives were involved to make decisions.

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 good. At this inspection this key question has now deteriorated 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

- Care plans did not always reflect people's physical needs. This meant personalised care could not always be provided as staff did not always know what people's needs were. For example, two care plans did not contain pressure wound management information to guide staff to offer consistent care.
- Technology used in the service was not easy to use and posed a risk people's care needs may not always be met. For example, we reviewed one person's care plan together with the unit manager who was unable to identify what support the person had received. Information was stored in multiple locations of the system. After significant scrutiny they could still not tell us whether the person's assessed support need was being met in line with their care plan.
- People and relatives were involved in planning people's care. One relative told us, "We've had care plan reviews."

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.

- People's communication needs were assessed and access to information in different formats was available (e.g. easy read text and large print). People were supported to use technology such as the internet and iPads to communicate with family. A new virtual reality headset had recently been purchased to provide different experiences to meet their communication needs.
- Staff communicated in different ways with people. One relative told us "[Relative] has very little speech now, but the staff have adapted how they communicate so [relative] can answer with a 'yes' or 'no'." This helped staff to offer choice and control to people to ensure their needs were met in a way that was acceptable to the person.

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 relationships that were important to them, both inside and outside the service. For example, a daily 'coffee morning' was attended by several people and they told us how they benefited from this social event. One person told us, "I really look forward to coffee morning so we can get together and have a chat, a bit like a coffee shop."
- People living with dementia were supported to engage with people with different needs. This helped to develop a sense of community in the service. One person told us, "There are "two or three of them [other

residents] we see almost all the time. It's nice to mix with other residents."

● People were provided with access to a wide range of activities. People who could not take part in group sessions were provided with 1:1 support. For example, we saw people supported in groups and individually to take part in making model poppies. During our inspection a staff member who co-ordinated activities arranged a meeting to discuss forthcoming activities. The staff member explained they consulted with people and used their feedback to develop activities.

Improving care quality in response to complaints or concerns

● A complaints and compliments policy and procedure was in place. People and their relatives felt able to raise concerns and equally compliments. One relative told us, "I haven't needed to raise any concerns but if I ask a question about [relative's] care it's answered well." Complaints were dealt with in a timely manner and recorded by the manager.

● Feedback was sought from people and relatives. Regular resident and relative meetings were taking place. One person told us, "I do believe we are part of running this place." People were able to share their views and suggestions, and management acted upon requests to make people's experiences more positive.

● People shared positive feedback. People, their relatives and professionals were complimentary about the care people received at the service. Relatives continually expressed their appreciation for staff and the quality of care provided to their family members.

End of life care and support

● People had end of life care plans in place. People's last wishes were documented, and people who were able to share their views were actively involved. One relative told us, "I was really impressed with [staff member] when we discussed the end of life plan. I thought it would just be 'DNAR yes or no' but [staff member] went into so much more detail, it shows how much they care."

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last two inspections the provider had failed to ensure quality assurance and systems and processes were in place to keep people safe. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Continuous learning and improvement; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Following our last inspection in March 2021 we took action that told the provider some steps they needed to take to drive and sustain improvements. However, at this inspection, we found similar concerns which showed not enough improvement to ensure people received safe care and treatment, and that the service was well-managed had been made.
- Management at the service had been inconsistent. The service had been supported by an interim manager and a manager had been newly appointed. The manager was in the process of registering with CQC but due to length of time CQC takes to register an application, the service continued to be without a registered manager for nearly seven months. While a regional manager was providing support to the service, the provider failed to ensure arrangements and support in place were sufficient to bring about improvements needed.
- While action plans were being completed, they were not always effective. A previous action plan dated 12 August 2021 confirmed an audit framework had been fully implemented to improve the quality of the service. We found not enough improvement had been achieved and partner agencies such as the local authority also continued to identify areas of concern. The provider had not developed oversight of the service to fully understand the amount of improvements and changes that needed to be made at the service. Significant shortfalls therefore remained.
- Systems and processes were not robust and failed to identify concerns in the safe administration of medicines, and the absence of important information in care plans to ensure staff could support people safely. Furthermore, the provider had not ensured staff were fully trained in all aspects of care delivery placing people at risk of receiving unsafe care.
- Areas of concern were not always independently identified. The manager and regional director had not established oversight of the service and had not independently identified issues highlighted by the inspection team. While the manager acted immediately to rectify concerns brought to their attention, we

were not assured robust measures were in place in the first instance to identify areas that needed to be improved.

Quality assurance and systems and processes to keep people safe were not effectively implemented to ensure the service was safely managed. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us the culture of the service was improving. The manager had a vision of the service and was empowering staff to understand their roles and responsibilities.
● The service demonstrated the importance of people being involved in their care. For example, activities were led and developed through people sharing ideas and suggestions, which were supported by staff.

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, relatives and staff told us the manager shared information more frequently. One relative told us, "We get plenty of emails with updates to visiting arrangements and other information, we're very well informed about what's going on."
● People and relatives held the manager in high regard. One relative told us, "The new manager is excellent; the care has improved as [the manager] gets more involved with the residents and proactively comes out of their office to meet relatives."
● The manager understood their responsibilities. When incidents occurred the local authority and CQC were notified accordingly. People's relatives also told us they were contacted if there were any concerns about their relatives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Records we reviewed confirmed people were involved in shaping their care. Some people told us they were able to choose activities they wanted to participate in, which helped to improve their wellbeing.
● Staff were confident to share their views. All staff we spoke with told us the management team encouraged them to share their views, and they felt valued. Several staff told us the manager had a genuine interest in their welfare.

Working in partnership with others
● The provider worked in collaboration with other agencies such as GPs and Social Workers.