RSJB Quality Care Homes Limited

Anchorage Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Anchorage Nursing Home is a 'care home' providing accommodation, nursing and personal care for up to 40 older people. At the time of the inspection 23 people were living at the home, some of whom lived with dementia.

People's experience of using this service and what we found
Systems in place to monitor the quality and safety of the service were not effective. Although internal and external audits identified areas for improvement, we found that action had not been taken to ensure those improvements were made. There was a lack of management oversight of staff practice to ensure best practice guidance was being adhered, and a lack of systems to ensure records were maintained accurately and stored securely.

Risks to people were not always managed safely, as care plans did not always provide information regarding people's current needs and how risks would be minimised. Identified risks were not robustly mitigated, as records did not evidence that people received planned care that met their needs. People's nutrition and hydration needs were not always met adequately. The environment posed risks to people as it was not safely maintained. Personal protective equipment was available for use when required. Medicines were not always stored and managed safely, as room and fridge temperatures were not monitored daily, and no action was taken when the temperature was out of recommended ranges. Best practice guidance was not followed, such as for the administration of covert medicines. Not all staff had had their competency assessed to ensure they were safe to administer people's medicines.

People, relatives and staff told us there were not always enough staff available to support people in a timely way. Our observations during the inspection supported this feedback. Not all safe recruitment practices were evident within staff files, and we made a recommendation about this. Not all staff received the necessary training to enable them to carry out their roles effectively, or relevant support, such as regular supervisions and an appraisal. However, staff told us they were kept updated and could raise any concerns with the management team.

Systems and procedures in place to safeguard people from the risk of abuse were not always effective, as although staff knew how to raise concerns, actions agreed to reduce risks to people were not always followed. Systems had been implemented to manage Deprivation of Liberty Safeguards and we found applications had been made appropriately. However, the principles of the Mental Capacity Act were not always adhered to when seeking and recording people's consent to their care and treatment, therefore people were not supported to have maximum choice and control of their lives.

Most people told us they were respected and treated well by staff, and staff told us they knew people's needs and how they wanted to be supported. People told us their family and friends could visit when they chose to, and we observed visitors in the home during the inspection.

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 July 2023) and there were breaches of regulation identified. At this inspection we found sufficient improvements had not been made and the provider was still 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.

Enforcement and Recommendations
We have identified breaches in relation to the management of risk and medicines, staffing, person-centred care, nutrition and hydration, consent and governance systems at this inspection. We also made a recommendation regarding staff recruitment practices.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Anchorage Nursing Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was undertaken by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Anchorage Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Anchorage Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This 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. Although there was a manager registered with the Commission, they were no longer in post. An interim manager had been in post for 5 months and a new manager had been recruited and was waiting to commence.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service, such as the infection control and end of life care teams. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with the regional manager, manager, director of quality, clinical nurse, as well as other members of the staff team including nurses, senior care workers, care workers, a domestic, chef and administrator. We also spoke with 12 people who used the service and 4 relatives, about their experience of the care provided.

We reviewed a range of records. This included 7 people's care records and a range of people's medication records. We looked at 4 staff files in relation to safe recruitment. A variety of records relating to the management of the service, including audits, were also reviewed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At the last inspection we found that risk was not assessed, monitored and mitigated safely, and the provider was in breach of regulation 12 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.

● Risks were not always managed safely, as identified risks were not robustly mitigated. Records did not evidence that people received planned care that met their needs, such as regular support to reposition, or adequate amounts of fluids.
● Care plans did not always provide detailed or consistent information on how identified risks would be minimised. For example, one person's care plans contained inconsistent information as to what sling was required for transfers, and another person's plan lacked detail as to how their health condition should be managed to ensure their safety.
● People were at further risk of harm as the environment was not safely maintained. We observed a wardrobe that was not securely fixed to the wall, fire doors that did not close securely in their rebates, bed rails propped up against bedroom walls and a sensor mat that was not working. The provider took action to minimise these risks during the inspection.
● Access to the home was not always secure, as a fire exit had been left open, giving members of the public direct access to the home.
● Peoples access to call bells was not always effective, as we observed a call bell mounted on the wall out of the person's reach.
● There was limited evidence of lessons learnt following incidents. Although accidents were recorded and reported, records showed actions agreed to reduce risks following incidents, were not always adhered to.

The failure to ensure risks were managed and mitigated, demonstrates a continued breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● External checks were completed to help ensure the safety of the building and equipment. Evacuation mats and window restrictors were in place.

Using medicines safely

At the last inspection we found that medicines were not always managed safely, and the provider was in breach of regulation 12 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.

● Medicines were not managed safely.
● Covert medicines were not always managed in line with best practice guidance. For instance, there was no clear care plan to guide staff how to administer a person's medicines covertly and the method of administration described by a staff member, was not in line with best practice. The guidance from the pharmacist as to how each medicine could be safely administered, did not include all medicines on the person's medicine chart.
● There were gaps in the recording of medicines and the stock balances for some medicines and supplements were not correct. Therefore, we could not be assured people received their medicines as prescribed.
● Best practices were not always followed, as creams were not all dated on opening and protocols for 'when required' medicines were not always available to guide staff when to administer them.
● Medicines were not always stored safely as fridge and room temperatures were not monitored dialy and maintained within recommended ranges. We observed prescribed creams stored in a communal bathroom and a person's fortifying agent stored on an open shelf. Thickening agent was also stored in an accessible cupboard in the dining room. This meant there was a risk it could be ingested accidentally, which could lead to potential choking incidents.
● Medicine administration competency assessments were not available for all staff who administered medicines.

The provider failed to ensure medicines were managed safely, this was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection prevention and control (IPC) practices were not always effective in minimising the risk of infections spreading.
● The kitchen was visually very dirty and there were no regular cleaning schedules available. We made a referral to the Environmental Health regarding this.
● Moving and handling equipment such as hoists, were visually dirty and there were no cleaning schedules available to ensure people's equipment was regularly cleaned.
● People's armchairs were ripped and could not be cleaned effectively. Records evidenced referrals had been made for new chairs.
● There was a strong malodour evident in one person's bedroom. This was investigated by the maintenance person, who advised it was the mattress which was immediately sent for a deep clean.
● Not all staff had completed IPC training to ensure they had the required knowledge to minimise risks to people.

This failure to adhere to infection prevention and control guidance was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Plans for redecoration and flooring replacements were in progress since the last inspection and there was evidence of improvements in some areas of the home.
● A new lift had been installed in the service since the last inspection.

● We observed adequate supplies of personal protective equipment (PPE) available for use when required.

Staffing and recruitment
● There were not always enough staff available to support people in a timely way. Staff told us there were not always enough staff, especially at weekends, and rotas reflected a drop in the number of staff available at the weekend.
● People told us they often had to wait for support. Comments included, "There's definitely not enough staff and the ones they have are just so busy", "The care could be better and what I mean by that is that there isn't enough staff so you are always being rushed or are waiting a long time" and "I'd like to see more staff. Yesterday there was only 1 staff member and they were running round doing all the care and it's not fair, we have to wait ages."
● Family members feedback also supported the lack of staffing; when asked if they felt there was enough staff they told us, "Well not today clearly, as the admin lady is in the kitchen", "There tends to be periods when there are not many staff around which is concerning not just for my relative" and "We try and come in to give our relative lunch because we want to get the food whilst it's hot and not have to wait."
● A SOFI (Short Observational Framework Inspection) assessment undertaken on the first day was abandoned due to lack of staff presence and interaction with people.
● Agency staff were utilised, but there was no evidence of staff profiles or induction for some current agency staff.

Failure to ensure safe staffing levels was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All staff files contained evidence of a Disclosure and Barring Service (DBS) check, which provides information including details about convictions and cautions held on the Police National Computer and helps employers make safer recruitment decisions. However, not all safe recruitment practices were consistently followed, as there were unexplained gaps in some staff members employment history, and other files did not include any employment history.

We recommend the provider reviews and updates practice to ensure all safe recruitment procedures are followed and recorded.

Visiting in care homes
● People were free to visit at any time in line with current government guidance. We observed family members visiting during the inspection.

Systems and processes to safeguard people from the risk of abuse
● There were systems and processes to safeguard people from the risk of abuse, however they were not always effective. We observed referrals had been made to the local authority when required, but records showed that actions agreed to reduce risks to people were not always followed.
● Safeguarding and whistle blowing policies were in place and staff knew how to raise concerns.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

At the last inspection we found the principles of the Mental Capacity Act (2005) were not always adhered to and the provider was in breach of regulation 11 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 11.

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 principles of the MCA were not always adhered to when seeking and recording people's consent to their care and treatment.
- When there were concerns regarding people's ability to consent to a specific decision, mental capacity assessments had been completed. However, records showed that the outcome of the assessment had been assumed prior to the assessment being completed.
- Decisions made in people's best interest with set timescales for review, had not been reviewed within those timescales.
- Records regarding Power of Attorney (POA), which gives nominated people legal authority to make decisions on a person's behalf, were not accurate. For example, one person's records showed their family member held POA, but there was no evidence of this, and the manager confirmed this was not correct.

Failure to ensure consent was sought in line with the principles of the MCA, was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems had been implemented to manage DoLS and we found applications had been made appropriately. For the authorisations that had expired, there was evidence steps had already been taken to contact the local authority to address this.

Staff support: induction, training, skills and experience

At the last inspection we found that staff had not received appropriate training or support to carry out their job roles effectively and the provider was in breach of regulation 18 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.

● Not all staff received the necessary training and support to enable them to carry out their roles effectively.
● Records showed that several staff had completed less than 35% of the provider's required training. Not all staff who were preparing food for people had undertaken recent food hygiene training to ensure they had the knowledge to do this safely and one staff member was not confident in the use of evacuation equipment.
● Records showed that not all staff received regular supervisions to support them in their roles.
● There was no evidence of annual appraisals.

Failure to ensure systems were in place to train and support staff effectively was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutrition and hydration needs were not always met adequately.
● It was not always evident that advice from health professionals such as the dietician, had been followed. For instance, a dietician recommended one person should receive a fortified diet and additional milkshakes each day. However, records did not reflect this was provided.
● We could not be assured people were receiving a fortified diet as required, as there was no regular chef in post and care staff and agency chef were unclear as to whose responsibility it was to provide the fortification recommended.
● Care plans included information regarding the support people needed to meet their nutritional needs. However, this information was inconsistent at times, and we observed the support documented within care plans, was not always provided by staff.
● Records showed that when people required their fluid intake to be monitored, they were not offered and did not receive the required amounts of fluids that had been assessed as necessary for them.
● When asked about meals available, people told us, "Sometimes it's not good, sometimes it's good depends who's on" and "Yes its ok. I don't think [there is a choice] it just gets given to us."

Failure to ensure people's nutrition and hydration needs were met was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed on admission to the home and plans of care developed.

● Recognised best practice was not always followed in the support provided to people, such as the administration of medicines and infection prevention and control processes.
● A range of policies were in place to support staff practice.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
● Referrals were made to other professionals when required to help ensure people's needs were met.
● People told us, and records showed that people could see a GP when they needed to.

Adapting service, design, decoration to meet people's needs
● Environmental improvements had been made since the last inspection, with refurbishment of communal areas.
● Doorways were not wide enough for people's specialist chairs to pass through them easily.
● There was only one wheelchair accessible communal bathroom available on the ground floor. As most people spent their time on the ground floor during the day, this could lead to people having to wait to use the bathroom.

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 requires improvement. The rating for this key question has remained 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; respecting and promoting people's privacy, dignity and independence

- Although people provided positive feedback about the staff that supported them, the provider's lack of effective systems in place to ensure good quality care was provided, did not demonstrate a caring service.
- Most people told us they were respected and treated well; they said, "The staff who are here are all very kind and helpful" and "They are all really nice, I haven't met anyone who isn't." A relative agreed and told us, "[Staff] are brilliant with [relative], they love her."
- Staff spoke fondly of people who lived in the home. They told us they knew people well and how they needed to be supported. However, they did not always feel able to care for people in the way they wanted to, and needed more staff to be able to spend time with people. Not all staff would be happy for their family member's to live in the home if they required support.
- Daily records and other records relating to people's care did not always show people received the care they needed. For example, monitoring records showed people did not always receive appropriate fluid, nutritional or repositioning support in line with their needs.
- As care plans did not always provide accurate or consistent information regarding people's needs, they did not guide staff to promote people's independence. Some plans however, did advise staff to ensure people's dignity was maintained when providing support.
- People's records and information regarding their care and support were not always stored securely in order to protect people's confidentiality.

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

- There were a lack of systems in place to enable people to share their views or make decisions about their care.
- Records showed resident and relative meetings were not held regularly to share information and to enable the provider to receive feedback regarding the service. Only one meeting was evident for 2023.
- We were informed monthly surveys were utilised to gather people's views, but no evidence of this was provided.
- People told us they had not seen their plan of care, although some relatives told us they had been involved in discussions about their family members care.
- There was a service user guide available that provided information about the home and facilities available, which could help people make decisions about their care.

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 requires improvement. The rating for this key question has remained 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; 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; end of life care and support

At the last inspection we found people did not receive care that was consistently person centred, and which considered their individual needs or promote choice and control. The provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- Care plans did not always show that care was planned in a person-centred way. People's care plans provided inconsistent information about their needs, which meant staff did not always have accurate and consistent information to provide person centred care to people.
- There were not always enough staff available to support people in a person-centred way. We observed people waiting to be supported with their lunch. When asked if they could choose when to get up and go to bed, one person told us, "I can yes, but you do have to wait quite some time. Even if you press the buzzer you are still left waiting." Another person's records showed they were not offered a bath as often as their care plan stated they would like.
- People's end of life care plans lacked detail and people's wishes and preferences were not recorded. Health professionals advised us the provider lacked relevant equipment that may be necessary to support people's needs at the end of their lives.
- There was an activities coordinator employed and a schedule of activities displayed, however most people told us there was not much going on in the home. Their comments included, "I do tend to stay in my room as there isn't anything else to do, it can get a bit lonely", "Well they are very nice but I'm very lonely here. I like to listen to music, but I don't have anyone to talk to" and a relative told us, "There is clearly no budget for entertainment, like some homes have singers and outings, there is nothing like that. Quite often the residents are just left sitting for hours with nothing to do." People told us there were no activities available out of the home.

Failure to ensure care was planned in a person-centred way to meet people's needs and preferences was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● People's communication needs were not always clearly recorded. Although care plans identified if people had visual or hearing impairments, they did not provide clear and detailed information as to how people's individual needs should be met.
● The management team told us information could be provided in different formats if people required this.

Improving care quality in response to complaints or concerns
● A complaints policy and procedure was available and was displayed within the home.
● People told us they could speak to staff if they had any issues.
● Records showed that although complaints were responded to, there was little evidence of actions taken to improve the service based on the feedback received.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. 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.

Continuous learning and improving care; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection we found the provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Systems in place to monitor the quality and safety of the service were not effective. Although audits had been completed, and some areas for improvement had been identified, we found that these were not always acted upon. For example, a kitchen audit and manager's walkabout audits had both identified the kitchen was dirty and required a deep clean, but this had not been addressed.
● Actions identified for improvement following safeguarding investigations, were not always consistently implemented, such as ensuring people's personal care support that was provided, or offered was recorded. A medicines audit completed in September 2023 identified several of the issues, and we found the same issues during inspection, so actions had not been taken to improve the service based on the findings of the audits.
● There was a lack of management oversight of staff practice to ensure best practice guidance was being adhered to and that any advised changes to practice, was embedded. For instance, a thickening agent prescribed for a person who was no longer in the home, was being used for several other people. The manager told us they had already raised this with staff and told them not to use it, but staff practice had not been monitored to ensure this was followed.
● Previously identified risks from external audits had not all been acted upon. For instance, a fire risk assessment completed in June 2023, identified concerns and these had not all been addressed, such as clinical waste bins not being locked securely.
● There were a lack of systems in place to monitor and oversee records within the service, to ensure they were maintained accurately and stored securely. People's care records did not reflect planned care was provided, and records such as training and supervision matrices did not reflect consistent, up to date information regarding staff employed by the provider.
● The findings of this inspection raised concerns with the management of the service and the safe delivery of care. The provider failed to ensure risks to people's health, safety and welfare were mitigated. Although

there was a manager registered with the Commission, they were no longer in post. An interim manager had been in post for 5 months and a new manager had been recruited and was due to commence shortly.

Failure to ensure safe and effective systems were in place to monitor the quality and safety of the service was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications had been submitted to the Commission as required, regarding reportable incidents. The ratings from the last inspection were displayed within the service and on the providers website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the last inspection we found the management arrangements in place to assess, monitor and improve the quality and safety of the service were not effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Records showed people's care was not always planned or provided in a person-centred way to ensure high quality care and good outcomes for people, that ensured their safety and wellbeing. This meant people were placed at risk of harm.
● Staff told us there were not always enough staff on duty and that this concern had been raised with the management team, but no changes had been made to improve this. People living in the home also told us they had to wait for the support they needed at times. The management team however, told us there were adequate numbers of staff available according to people's dependency assessments.
● Not everybody knew who the current manage of the service was. Some people thought the regional manager was the manager and told us, "Well I know [Regional Manager] is one of the managers and she is very kind and helpful, but she is always so busy" and "[Regional Manager] she's the boss, she's lovely." Other people knew who the manager was, although one person said, "I've not met him, he hasn't been in here to introduce himself. To be honest we never see them."

Failure to ensure systems in place promoted good outcomes for people was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most staff told us they could approach the management team if they had any concerns and they were usually kept up to date with changes within the home. Relatives also agreed they were usually kept updated and could speak with staff or the manager if they had any issues.
● Relatives told us they were informed of accidents or incidents involving their family members.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others
● There was a lack of evidence of engagement with people and their relatives regarding the service and the care provided. There was no evidence of any recent staff meetings being held.
● Verbal feedback given at the end of the first day of inspection, had not been acted upon by the second day of inspection. This showed a lack of responsiveness in partnership working.

- Systems were in place to ensure referrals were made to other professionals when required.