Careline Lifestyles (UK) Ltd

# St Stephen's Court

## 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? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
St Stephen's Court consists of individual units providing care and support for people who have acquired brain injuries, neurological conditions, mental health needs and learning and physical disabilities. The home can accommodate up to 30 people. There were 30 people living there at the time of our inspection.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

People's experience of using this service and what we found
The outcomes for people did not fully reflect the principles and values of Registering the Right Support.

Safeguarding policies and procedures were not always followed when safeguarding allegations had been made. People were not consistently supported in the least restrictive way possible. The provider had not notified CQC of all safeguarding incidents in line with legal requirements. These omissions meant that CQC did not have oversight of all safeguarding allegations to make sure that appropriate action had been taken.

Timely action had not been taken to ensure the premises and equipment were well maintained. Some parts of the home were not clean and there were offensive odours in certain areas. Not all of the décor, furniture and furnishings were in a good condition.

Medicines were not always managed safely, and records had not always been completed correctly.

Safe recruitment practices were not always followed. People and staff told us there were not always enough staff deployed to ensure people's wellbeing and meet their social needs. Some staff were regularly working long hours to cover shifts.

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

An effective system to ensure staff were supported was not fully in place. People did not always have choice and control regarding their diet.

Staff were not always proactively engaged with people. They sometimes talked amongst themselves rather than engaging with people. The language used by some staff in care records did not promote people's

dignity.

People were not fully supported to follow their hobbies and interests. Some people told us they were bored and said there was a lack of activities to occupy them. People did not always receive specific care and support to meet their needs and preferences. Staff worked in ways which restricted certain people's choices.

A complaints procedure was in place. However, records did not always demonstrate that this procedure had been followed.

Serious shortfalls identified at this inspection, had not been identified by the provider's quality assurance system. Management staff had not effectively identified and managed risk therefore, people were placed at risk of harm.

Some staff explained that morale was low at times. They told us that this was due to staffing levels and certain staff not working together as a team.

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

Rating at last inspection
The last rating for this service was good (published 22 June 2018).

Why we inspected
The inspection was carried out due to concerns we received about people's care. A decision was made for us to inspect and examine those risks.

Enforcement
We identified multiple breaches during the inspection. These related to safeguarding people from the risk of abuse and improper treatment, need for consent, safe care and treatment, dignity and respect, person-centred care, staffing, good governance and fit and proper persons employed. We also identified a breach of Regulation 18 (Notification of other incidents) and Regulation 12 (Statement of purpose) of the Care Quality Commission (Registration) Regulations 2009.

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 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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?

**Inadequate**

The service was not safe.

Details are in our safe findings below.

### Is the service effective?

**Inadequate**

The service was not effective.

Details are in our effective findings below.

### Is the service caring?

**Inadequate**

The service was not caring.

Details are in our caring findings below.

### Is the service responsive?

**Inadequate**

The service was not responsive.

Details are in our responsive findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-led findings below.

# St Stephen's Court

**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 was carried out by two inspectors and a pharmacy inspector.

Service and service type
St Stephen's Court 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
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 professionals who work with the service. We used all of this information to plan our inspection.

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.

During the inspection

We spoke with 12 people who used the service about their experience of the care provided. We spoke with 23 members of staff including the nominated individual, head of care outcomes manager, head of care delivery manager, registered manager, and a manager from one of the provider's other care homes. The nominated individual is responsible for supervising the management of the service on behalf of the provider. In addition to this we also spoke with a physiotherapist and occupational therapist employed by the provider. We also spoke with a visiting healthcare professional to find out their opinions of the care provided.

We reviewed a wide range of records. This included 12 people's electronic care records. We looked at nine 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 shared all of our concerns with the police, local authority and clinical commissioning group. We also contacted a further 24 visiting health and social care professionals by e-mail to request feedback of their opinions of the care provided. We received additional feedback from a further three visiting health and social care professionals. Five professionals responded to advise they were unable to provide recent feedback regarding the service. One professional declined to comment and 15 professionals did not respond to our request for feedback.

Inadequate

# 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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems were not operated effectively to safeguard people from the risk of abuse. For example, body map documents detailed bruising to people which recorded the cause of an injury as unknown. Action had not been taken to investigate how these injuries may have been sustained. The provider did not assess if for example, the bruising could be linked to staff restraint practices. Following our inspection the provider told us the registered manager had reasonably attributed the injuries one person had sustained to incidences of staff restraint and self-harming.
- Safeguarding policies and procedures were not always followed when safeguarding allegations had been made. Staff did not always recognise incidents of a safeguarding nature and not all safeguarding allegations had been referred to the appropriate authorities.
- People were not consistently supported in the least restrictive way possible. This resulted in some people having unlawful restrictions placed upon them.
- Due to several concerns of a safeguarding nature, the local authority had placed the home into 'organisational safeguarding.' This meant that the local authority was monitoring the whole home.

The lack of robust systems and processes to safeguard people from abuse was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks relating to people and the environment had not been effectively assessed and monitored.
- Timely action had not been taken to ensure the premises and equipment were well maintained. On the first day of the inspection three internal doors had tape applied to the glass panels due to the glass being broken. We were told these doors had been like this for seven to eight weeks. The glass panels remained broken when the inspection concluded four weeks later.
- Care plans and risk assessments were not always up to date and did not reflect people's current needs. Records lacked guidance to alert staff on how to monitor and support people who had specific health issues. For example, the eating and drinking care plan for one person recorded staff were to offer 'full support and guidance' but did not contain specific detail of the support required. Following the inspection the provider wrote to us confirming care staff had not kept records to document when topical creams were applied to people.

Preventing and controlling infection

- An effective system was not in place to prevent cross infection.
- Not all areas of the service were clean and there were offensive odours in certain parts of the home. This

impacted upon other people within the environment. No risk assessment was in place to address this.
● Staff had access to gloves and aprons. However, other protective equipment such as shoe covers were not available. This was required as staff were cleaning bodily fluids from parts of the environment. There was a risk of cross infection where staff were moving in and out of areas where they could be exposed to and spread bodily fluids around the environment.
● Some of the furniture had fabric coverings which were difficult to keep clean and some were malodourous.
● Timely action had not been taken when concerns had been raised from staff about infection control.

Failure to adequately assess, monitor and mitigate risk placed people at significant risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely and records had not been completed correctly. Relevant national guidelines were not always followed.
● There was no guidance for care staff about where or how often to apply creams. Care staff did not record when creams were applied.
● There was no staff guidance about as required medicines. Staff did not always record why these medicines had been given or whether they had been effective. This is required to ensure consistent administration by staff.

The failure to have an effective system in place to manage medicines safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment practices had not been followed. We reviewed records for four staff and found shortfalls with all recruitment checks. Some application forms were not fully completed; gaps in the employment history for potential employees had not been considered in the recruitment process; appropriate pre-employment checks had not always been completed for example, checking references.
● Risk assessments were in place for staff who required these. However, the measures identified by the provider to supervise staff were not being completed.

The lack of robust recruitment systems demonstrated the provider was in breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider used a dependency tool to assess the required number of staff to meet people's needs. People and staff told us there were not always enough staff deployed to ensure people's wellbeing and meet their social needs.
● Staff sickness levels within the home were high. The provider used agency staff and some staff were regularly working long hours to cover shifts.

Learning lessons when things go wrong
● Lessons learnt were not always identified following accidents and incidents to reduce the risk of any reoccurrence.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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
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.

- Consent to care and treatment was not fully sought in line with relevant legislation and guidance.
- Staff did not have a robust knowledge of the MCA and as a result placed unlawful restrictions upon people. For example, one person who was assessed as having capacity to manage their own finances had restrictions placed upon them regarding how much money they were allowed on a daily basis. There was a lack of staff knowledge regarding the ability of a person with capacity to make what other people may consider an unwise decision.
- Certain decisions were being made on behalf of people who lacked capacity without the principles of the MCA having been followed. Equipment such as bed rails and lap belts were being used for some people without best interest decisions having taken place.
- Records did not always demonstrate staff worked within the principles of the MCA. For example, staff removed personal belongings and switched off the electricity in one person's bedroom. No record of any best interests decision was available to show why this action was necessary or that it had been assessed as being the least restrictive option.

The failure to ensure the principles of the MCA were followed was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● An effective system to ensure staff were supported and trained was not fully in place. Not all supervisory staff had completed supervision and appraisal training.

● Staff supervision and appraisals had not been carried out at the frequency identified by the provider. For example, it was assessed one member of staff should receive weekly supervision. However, their records evidenced they had only received two supervisions in 2019.

● Staff told us they had raised some concerns regarding staffing during supervision sessions. It was not clear what action had been taken in response to this.

● An effective system was not in place to observe staff practices to ensure the correct procedures were carried out, for example during restraint. Several staff were suspended during the inspection due to concerns regarding their practice.

● Some staff told us they did not always feel supported and morale at the home was low. The registered manager confirmed they were aware of these issues. They described ways they had tried to make staff feel valued.

The failure to ensure staff were supported was a breach of Regulation 18 (Staffing) 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

● Preadmission assessments were carried out.

● People's assessed needs and choices were not always kept under review to ensure care and support reflected their needs and was person-centred. Such as, people assessed as having capacity to make certain decisions being restricted from doing so.

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

● Not all of the décor, furniture and furnishings were in a good condition. One person showed us where there was mould in their room and areas where the floor was uneven. They said, "The problems that are going on here isn't the managers fault it's the owners. It's things like the windows being fixed and the washing machines are not being fixed quick enough. There's a hole in my laminate flooring and it's getting bigger, it feels like there's a bit missing when you stand on it." The registered manager confirmed there were some issues which needed to be resolved within the environment and with equipment.

● Some people told us that a recreation room would be appreciated to play games.

● There was a hydrotherapy pool. Some people and staff told us this was not used as much as they would like, because of the lack of trained staff to support people in the pool. The registered manager confirmed staff could not support people in the pool unless they had received the relevant training. The training matrix evidenced less than five percent of the staff team had completed this training. Following the inspection the provider wrote to us to explain staff training for this was not mandatory. The provider advised additional trained staff from their internal therapy team were available to support people in the hydrotherapy pool who wanted to use it.

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

● People did not always have choice and control regarding their diet and there were some restrictions in place for what some people could eat. One person said, "We have to order food from a ridiculously expensive catering catalogue. There would be so much more choice if they [staff] were able to go to [name of supermarket] or somewhere else." We brought this to the attention of the registered manager and head of care delivery manager who confirmed the current system restricted the choices available to people. The head of care delivery manager told us the provider was looking at the current system to change how food was ordered to allow more choice to be available for people.

● Cooking clubs were held and some people were supported to make their own meals.

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

● People had access to health and social care professionals such as the GP and social workers. One healthcare professional told us, "From my perspective I have no concerns, I think they do an incredible job with a lot of complex people." A second visiting professional said, "I have observed staff to respond swiftly to intervene and defuse confrontation [with people] with the manager leading and modelling good practice."

● People received a learning disabilities annual health check with their local GP and hospital passports were in place.

Inadequate

# 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 inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- Due to the concerns identified during the inspection, we could not be assured the provider ensured people received a high-quality compassionate service.
- Several staff were suspended during the inspection due to concerns or allegations regarding their practice. This exposed people to the risk of abuse and avoidable harm. One person told us, "I wouldn't recommend other people to live here as it's not a nice place at the minute." Another person said, "The staff don't treat us equally and treat us differently."

The lack of robust systems and processes to safeguard people from abuse was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were not always proactive in responding to people's concerns. Assumptions were made that people's concerns were down to their condition which resulted in staff failing to investigate all allegations. One person said, "They [staff] say it's someone crying wolf. They don't believe me because I take tablets."
- The use of positive behaviour support was not understood by all staff. Positive behaviour support is a behaviour management system used to understand distressed behaviour and guide staff on the actions to take to help reduce anxiety or distress.
- Staff were not always proactively engaged with people. Throughout the inspection staff were observed to be talking amongst themselves rather than engaging with people.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not always supported to make their own decisions which sometimes resulted in the escalation of incidents. This included one incident where staff recorded the person involved could be overheard crying as a result of their interaction with staff.
- The language used by some staff in care records did not promote people's dignity. We viewed documentation which described people being 'mappered' to record a restraint incident.
- People were not always treated with dignity and respect. One person described how some staff whose first language was not English would speak to each other in their native language while working. We brought this to the attention of the registered manager and head of care delivery manager who confirmed this had previously been reported to them. The head of care delivery manager assured us this issue would be raised with staff again.

The failure to promote dignity and respect was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# 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 good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not fully supported to follow their hobbies and interests. There were not enough meaningful activities for certain people, especially those who could not communicate verbally. For example, some records described activities for people as 'watching the television' or 'relaxing on the sofa'.
- Some people were bored and said there was a lack of activities to occupy their attention. Some behavioural records highlighted the trigger for the behavioural incident as boredom or a lack of activity. One person said, "There's no activities, that's why people are drinking and smoking [drugs]."
- An activities programme was in place. The registered manager told us this was not followed but did not provide an explanation as to why. Staff had raised in team meetings the need for more activities to be available for people.
- Records did not demonstrate staff proactively sought to meet people's social needs. Some records described people being told their chosen activity was not available due to staffing issues.

The failure to ensure people's social needs were met was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Activities observed during the inspection included karaoke singing. People actively engaged with staff during this session and gave positive feedback of their enjoyment.

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

- People did not always receive specific care and support to meet their needs and preferences. Support was not always provided to people as detailed in their care plans. For example, for one person with diabetes all the measures identified to manage this condition were not being completed. Staff told us they were unaware of all of the actions recorded in the care plan in relation to this.
- Not all staff understood the principles of positive behaviour support and did not always follow best practice guidelines with regards to this area.
- Staff worked in ways which restricted people's choices. For example, people were unable to eat a dessert everyday if they chose to. Minutes from a staff meeting recorded a question of whether people could have a pudding every day. The response to this stated, 'Unfortunately not, we have to be seen to promote healthy eating within the home.' There was no evidence to show this had been considered on an individual basis for people or if healthier alternatives could be made available to people who wanted them.
- Reviews of some people's care and support had not been carried out at the frequency identified by the

provider.

The failure to provide care which met people's needs and preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● A complaints procedure was in place. However, records did not always demonstrate this procedure had been followed.

The failure to ensure accurate records were maintained in relation to complaints, was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● No one receiving end of life care at the time of the inspection.
● Most staff had completed end of life training.
● Staff were organising one person's funeral. Staff explained about the importance of making sure arrangements were in place to ensure people and staff could pay their respects.

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 recorded in their care plans. One staff member told us they would appreciate undertaking Makaton training to improve their communication with one person who used this form of communication.
● Some information was available in accessible formats. For example, some easy read documents had been produced to support people who could not understand written words.

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 requires improvement. At this inspection this key question had now deteriorated to 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.

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

- Serious shortfalls identified at this inspection, had not been identified by the provider's quality assurance system. Ten breaches of regulation were identified during the inspection.
- Management staff had not effectively identified and managed risk therefore, people were placed at risk of avoidable harm.
- Some electronic records were amended by staff after the initial recording was made. These documents did not demonstrate why additions to records were being made, why additional information was required or how the extra information was known and was not recorded at the time of the initial report. In addition, the nominated individual was unaware this practice took place.
- It was not clear what action was taken by the supervisor when concerns were raised by staff in supervision sessions. One staff member said, "I feel supervision is a waste of time it doesn't get acted upon."

The failure to embed robust quality assurance systems was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not notified CQC of all safeguarding incidents in line with legal requirements. These omissions meant CQC did not have oversight of all safeguarding allegations to make sure that appropriate action had been taken.

The failure to inform CQC of notifiable events is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. This is being followed up outside of the inspection process and we will report on any action once it is complete.

- The provider had not ensured the 'Statement of Purpose' for the location was up to date. A statement of purpose is a legally required document that includes a standard set of information about a provider's service.

The failure to ensure legally required information was kept up to date and submitted to CQC was a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009. Statement of purpose. This is being followed up outside of the inspection process and we will report on any action once it is complete.

Continuous learning and improving care; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● An effective system to learn from accidents and incidents and prevent any reoccurrence and improve people's care was not in place.

● Staff morale in the home was low. Staff told us this was due to staffing levels and certain staff not working together as a team. The registered manager was aware of this and spoke of ways to try and improve morale such as organising a team day outside of work.

● Some staff told us timely action was not taken in response to the issues they raised. One staff member said, "It's a strange waiting game, things don't get done as quickly as we would like." The registered manager told us staff had the opportunity to share any issues or concerns at supervision sessions and team meetings. However, we viewed minutes of staff meetings and supervision sessions where some issues had been repeatedly raised.

● A culture of high quality, person-centred care which valued and respected people's rights was not embedded within the service. This was evident by the breaches of regulation identified during this inspection.

Working in partnership with others

● The management team had not pursued all concerns raised by people and staff. There was a lack of evidence to demonstrate what action had been taken in response to concerns raised by staff during supervision sessions. Some supervision documents recorded limited information and the 'manager comments' section of supervision records were not always completed.

● Meetings to obtain feedback from people had not been successful. The registered manager told us people had refused to attend the last meeting organised to seek their views. Questionnaires were used as another way to seek the views of people.

● Staff worked with other organisations and stakeholders such as the local authority and health and social care professionals.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had not notified CQC of all allegations of abuse. |

**The enforcement action we took:**

We did not proceed with enforcement action in respect of this breach.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems were not operated effectively to safeguard people from the risk of abuse. Safeguarding policies and procedures were not always followed when safeguarding allegations had been made. People were not consistently supported in the least restrictive way possible. Regulation 13 (1)(2)(3)(4)(b). |

**The enforcement action we took:**

We issued an urgent notice of decision to impose conditions upon the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Safe recruitment procedures were not always followed. |

**The enforcement action we took:**

We issued an urgent notice of decision to impose conditions upon the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>An effective system was not in place to ensure staff were supported. |

**The enforcement action we took:**

We issued an urgent notice of decision to impose conditions upon the providers registration.