Boulevard Care Limited

Welham House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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
Welham House is a residential care home providing personal care to up to 14 people. The home provides support to people with a learning disability or autism. At the time of our inspection there were 13 people living at the home.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
The service did not support people to have the maximum possible choice, control and independence and control over their own lives. There were no assessments in place about what decisions they could make for themselves.

Staff failed to focus on people's strengths and did not promote what they could do. People spent time sitting around with nothing to do. They were not supported to take part in household chores such as cooking or washing and care plans lacked information on how to increase people's independence. The provider had not supported people to take part in activities and pursue their interests in their local area.

Staff expected people to become distressed and lacked information on de-escalation techniques for each person. This led to people being restrained. The provider did not monitor the level of restraint in the home and staff did not learn from incidents.

The service gave people care and support in a clean, well-furnished environment that met their physical needs. People had a choice about their living environment and were able to personalise their rooms.

Staff enabled people to access specialist health and social care support in the community. However, information provided by staff to healthcare professionals was not supported by documented evidence.

Medicines were not safely managed, and staff did not support people with their medicines in a way that promoted their independence and achieved the best possible health outcome.

Right Care:
Staff did not understand how to protect people from poor care and abuse. The service failed to work well with other agencies to do so. Staff had training on how to recognise and report abuse but lacked the skills to put their training into practice.

Staff had received training, but this had not been of a suitable quality to ensure staff had the skills needed to meet people's needs and keep them safe. Staff did not understand how to provide care in line with national guidelines and to reduce restrictions on people.

Risks to people were not properly identified and assessed. Therefore, care was unable to be planned to keep people safe from repeated incidents.

People were not offered activities or the opportunity to pursue interests that were tailored to them.

Right Culture:
There was a closed culture in the home, with a lack of transparency to external organisations. Staff did not raise concerns as they were worried about their jobs. Staff did not understand best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. Therefore, people received more restraint both physical and chemical than they may have needed.

Staff manipulated the homes routines to make their roles easier and failed to place people's wishes, needs and rights at the heart of everything they did. There was no reflection on the quality of care provided and how it impacted on the people living at the home.

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 5 April 2019).

Why we inspected
The inspection was prompted in part due to concerns received about allegations of abuse within the home. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.
The provider has been responsive to concerns raised and has taken immediate action to mitigate risks in the home.

Enforcement and Recommendations
We have identified breaches in relation to the use of restraint in the home, the management of risks to keep people safe, the management of medicines, the number of staff on duty and their training, keeping people safe from abuse, assessing people's capacity to consent, quality of information in the care plans, the level of activities offered to people and the governance of quality and safety of care at this inspection.

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

We have imposed conditions on this location to help keep people safe. The conditions require the provider to get external expertise in relation to medicines management and positive behavioral support as well as reducing risks to people when they go out of the home. We require the provider to submit monthly information to us so that we can monitor the quality of care they are providing.

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.

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 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 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**

Welham House

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 team consisted of 2 inspectors.

Service and service type
Welham House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Welham House is a care home without 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.

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. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who lived at the home and 2 relatives. We spoke with 2 members of staff while we were at the home and contacted others by telephone. We spoke with a senior care manager, a locality support manager and the registered manager from 1 of the providers other homes who visited to support the inspection.

We looked at the care and support plans for 7 people living at the home and the medicine administration records for everyone. We also looked at management records within the home to assess the safety of the service.

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 Good. At this inspection the rating has changed 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

- Staff had received training in how to keep people safe from abuse. However, they had not raised concerns about poor practices within the home. This meant issues were not raised with the provider or external agencies.
- People had not received information on how to keep themselves safe. This meant people did not recognise when staff did not support them appropriately. A person told us how a member of staff would get angry at them and punish them to help them learn to control their behaviour. They did not understand this was unacceptable from staff and did not know how to raise concerns.
- Investigations into safeguarding concerns were not robust and failed to consider all the information needed to ensure people were kept safe. For example, when a person made a disclosure at a healthcare setting this was not raised with the local authority safeguarding team.
- Records of people's money and spending did not support safe management of money. Records were generic, did not fully list what had been brought and receipts were not always available. For example, 1 person's record listed they had a takeaway and the amount spent but there was no receipt or list of what they had eaten.

Systems had not been established to protect people using the service from abuse and improper treatment. This placed people at risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's care plans lacked information on how to support them when they were upset or distressed. Care plans guided staff to manage upset or distress by use of physical restraint. There was no guidance for staff on how to use less restrictive approaches in the first instance.
- Where risks were identified care was not planned to keep people safe. For example, people were not always supported to access the community safely and with the number of care staff identified as needed to keep themselves and the public safe.
- Other risks to people had not been identified. For example, when people had repeated falls. No action was taken to identify the cause of the fall or if any action could be taken to either reduce the risk of falls or reduce the likelihood of injury when people fell. □
- There were no risk assessments for some people's health conditions. For example, 1 person was living with epilepsy, there was no risk assessment or effective care plan in place to monitor this. This meant staff lacked guidance on how to react when the person had a seizure or how to identify if the person's condition was deteriorating.

●There was no evidence of lessons being learnt from accidents or incidents. Records of restraint incidents were inadequate and did not fully describe the situation. Instead, they used vague descriptions like 'management strategies were implemented'. This meant that the provider would be unable to assess if staff had supported the person safely and in line with their care plan and if any learning could be identified from the incident.

Using medicines safely

● Medicines were not safely administered. Staff did not follow the provider's policy of administering medicines to 1 person at a time. Instead, we saw staff dispensed people's medicines into individual pots and once everyone's medicine was dispensed they called people to the office to take their medicines. Once everyone's medicine had been taken them all the Medicine Administration Records (MAR) were signed. This could lead to multiply errors occurring.

● On the first and second day of our inspection staff had not had their competency checked to ensure they administered medicines in line with the provider's policy. On the third day a senior care worker confirmed they had received a competency check after our second day of inspection. However, they continued to administer the medicine in an unsafe manner. This meant there was an increased risk of medicine errors occurring.

● Some people were prescribed medicines to be taken as required (PRN). For example, medicines to help them manage their emotions or to reduce pain. Protocols in place to support staff to administer these medicines consistently and safely were insufficient. This meant people were at risk of not receiving their medicines as needed. For example, we saw 1 person had received 3 doses of an as required medicine in 24 hours when the prescription noted the maximum dose within 24 hours was 2.

Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People's 1 to 1 needs had not been fully identified or provided. On day 1 of our inspection, staff were unclear about who received 1 to 1 support. On the third inspection day, head office staff had clarified 4 people's 1 to 1 support and only two of these people had this support consistently in place.

● In addition, social worker reviews had identified a further person who should have 1 to 1 support in place. Family members told us they had raised at reviews that people's identified support needs were not in place. A relative told us, "Whenever we have had [review] meetings we have raised several times about [Name's] 1 to 1 hours and get met with we haven't got the staff." Relatives told us this impacted on people's abilities to take part in activities outside the home.

● Managers did not arrange shift patterns so people who were friends or family did not regularly work together. This meant there was an increased risk of a closed culture and concerns not being documented or raised within the home or with the provider.

● Staff were safely recruited. Disclosure and Baring (DBS) checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The provider had not ensured there were enough staff to meet people's needs. This put people at risk of not having their needs met. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were supported to maintain contact with their family and friends. There were no visiting restrictions and staff welcomed visitors to the service at any time.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff had not received all the training needed to support people safely. Records to support staff training was poor therefore it was not possible to ascertain what training staff had completed and what still needed doing.
- The training provided had been ineffective. For example, medicines training had not supported the safe administration of medicines and training on managing distressed behaviour had not prompted staff to de-escalate before restraining people.
- Staff had not received support in the form of continual supervision, appraisal and recognition of good practice. When staff had to use restrictive practice, there were no debriefing meetings and staff were not supported to reflected on their practice to consider improvements in care.

Systems had not been established to ensure staff received appropriate support and training. This put people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People's ability to make decisions for themselves were not properly assessed and where needed MCA

assessments and best interest assessments were not in place. For example, 1 person whose care plan noted they lacked insight into their finances was asked to sign consent for paying for their own takeaways.

Systems had not been established to ascertain people's ability to make decisions for themselves. This placed people at risk of not having their right to consent to care respected. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where needed DoLS were in place to keep people safe. However, we saw the front door was unlocked, and people could independently access the front garden and would be able to leave the premises unobserved. While there was no one who was actively exit seeking there was a risk a person unable to keep themselves safe could access the community.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's healthcare needs were not fully supported. Staff did not always follow advice from healthcare professionals to monitor people's health. For example, we saw 1 person needed to have their blood pressure monitored following a doctors appointment in August but this had not been done. Once we raised this with staff they ensured this monitoring was completed.
● People did not have health actions plans/ health passports, therefore there was no formal documentation to support people when they needed to access health and social care. This meant there was a risk they may not be supported in the way they needed.
● People received annual reviews of their needs. However, relatives told us they had felt excluded from people's healthcare reviews and their input into their relatives' health had not been supported. We asked relatives if they attended annual or health reviews, a relative told us they would like to but felt excluded. They said, "It's like this little click and I can't get into the click." This meant there was a risk of relatives' views about what care was in the best interest of people may be missed.
● People were reliant on staff being open and honest with health professionals to advocate for them. However, there was a lack of documentation to support changes in people's needs and so the information shared may not have been fully accurate and may reflect staff's bias on people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Implementation of evidence-based guidance was variable. People's care and support plans were not personalised or holistic. They did not focus on people's strengths and failed to reflect their needs and aspirations, including physical and mental health needs. For example, there was no recording of people's aspirations in their care plans, they had no goals to aim for and there was no record of any program to increase people's independence.
● Recognised tools were not used to identify people's level of risk or to reduce incidents and accidents. For example, a person, who had multiple falls did not have a falls risk assessment in place and no action had been taken to reduce the risk of this person falling.

Supporting people to eat and drink enough to maintain a balanced diet
● People were happy with the food provided. People could have a drink or snack at any time, and they were given guidance from staff about healthy eating.
● People were not fully involved in choosing their food and planning their meals. There was a 3 week rota of meals in place and alternatives were not included on the rota offered. A person told us they did not know if they could choose what to eat.
● People were not always supported to be involved in preparing and cooking their own meals in their preferred way. A member of staff explained when they worked in the kitchen there was no involvement from

the people living at the home in preparing their meals.
● People's ability to eat and drink safely was monitored. Where needed, advice from healthcare professionals was sought and meals presented to people in a way they could eat safely.

Adapting service, design, decoration to meet people's needs
● The provider had not ensured they had fitted temperature regulating valves to all the hot water taps. This meant the water at the hot water taps in the home were of a temperature which could potentially scold people. When we raised this with the provider they took immediate action to keep people safe.
● People personalised their rooms and were included in decisions relating to the interior decoration and design of their home

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Some of the language used in documentation showed staff did not see people as their equals. For example, in a person's behaviour chart we saw the lesson learnt was recorded as to "keep as far away from the person as humanly possible". In another one it noted the person could be unreasonable in their requests and staff should ensure ample space was maintained to prevent the person being able to make aggressive physical contact with them. There was no acknowledgement people needed kind and compassionate care from staff.
- Some staff were not mindful of individual's sensory perception and processing difficulties. Records were written as if the person had deliberately targeted staff. There was a lack of understanding that some people may not have the ability to regulate their emotions.
- Incidents were viewed from the staff viewpoint. For example, "[Name] continues to attack staff."

Some staff did not always treat people kindly. A person told us staff shouted at them. They told us "It's because I am bad." This showed staff did not use appropriate styles of interaction with people and did not support people's wellbeing.

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

- People were not always enabled to make choices for themselves. One person told us they had to go to bed at 9pm and they had no choice about this. Another person told us they did not know if they were able to choose what to eat. This meant people were not always able to make choices about their everyday lives.
- People were not supported to understand prejudices. This led them to make inappropriate remarks in public and put them at risk of harm. No risk assessment or education programme was in place.
- People's independence was not being supported. For example, people were not encouraged to wash their own cloths or take part in food preparation. A member of staff told us, "People not allowed to do their own washing. We do all the washing." A relative told us, "[Name] has not been helping in the kitchen." This meant people were unable to gain new skills and decrease their reliance on staff. Following our inspection, the provider was looking at increasing people's ability to look after themselves.

Systems had not been established support the independence and autonomy of people. This placed people at risk not being treated with respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. At this inspection the rating has changed to requires improvement: This meant people's needs were not always met.

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

- Care plans were not fully reflective of people's needs. There was a focus on restrictive practices such as restraint in care plans and staff failed to offer other methods to support people. There was a lack of awareness of recognised models of care and treatment for people with a learning disability or autistic people. For example, 1 person's physical restraint care plan noted the person had always displayed aggression. There was no understanding this was the way the person showed their emotions.
- People were not supported to learn everyday living skills or develop new interests by following individualised learning programmes with staff who knew them well. Care plans lacked information about how people should be supported with their washing, ironing, cooking and cleaning.

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.

- There was some recording of people's communication needs within their care plan. However, they were not always up to date. For example, 1 person was recorded as having a computer tablet to help them communicate and this was no longer in place. This meant a means of communicating had been removed from the person. Following the inspection action was being taken to reinstate this method of communication.
- People did not have separate communication passports to take with them when they accessed health and social care services. This meant there was a risk they may not be able to be understood or make their voice heard when in other settings.

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 provided with opportunities to develop hobbies or work opportunities to improve their skills and life experience. For example, 1 person's care plan noted they needed structured activities planned to help them remain settled. There were no structured activities planned on a daily basis to support this person.
- Relatives told us staff were negative about options for people to go out of the home. A relative told us, "[Name] does not go out anywhere. Staff keep them in their bedroom. Every time I try to set up an outing, I am told they will not manage things." Another relative said the lack of activities was, "Impacting on [Name]

as they never go out and sits at home."
● Lack of staff impacted on people's ability to get out of the home. Staff told us when they did plan activities, like a visit to another home, this often had to be cancelled as no one had organised the staff to support this.

Systems had not been established to ensure people's care was reflective of their needs and met their preferences. This placed people at risk of receiving poor quality care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● People living at the home and their relatives told us they would raise complaints with staff. However, no one had raised a formal complaint.
● The provider had a complaints policy. They told us they had received no complaints in the last year.

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 requires improvement. At this inspection the rating has changed 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

- There was no registered manager for the service. There had not been one since February 2022. While there had been a series of managers, overseen by a location support manager there had been ineffective management of the home and care provided. A relative told us, "There have been multiple changes of manager and they just keep replacing them."
- Senior staff within the home and the location support manager had failed to understand and had not demonstrated compliance with regulatory and legislative requirements. We had not been notified about incidents the provider was required to tell us about by law. This meant ongoing monitoring of the home was not effective.
- The location support manager and senior staff within the home had failed to understand their duty to keep people safe and raise safeguarding concerns appropriately. They had not kept external professionals up to date with events. For example, a safeguarding had not been raised when a member of staff had been suspended and investigated for alleged abuse.
- Governance processes were ineffective and failed to hold staff to account, keep people safe, protect people's rights or provide good quality care and support. The audits in the home were ineffective at identifying concerns or driving improvements in the home. For example, audits had not identified concerns found with risk management, medicines, safeguarding or ensuring lessons were learnt as detailed in the safe section of this report. In addition, there was a lack of oversight by the provider to identify these gaps in monitoring.

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

- The provider had not developed an open culture in the home. There was a belief staff were always in the right and there was a core group of staff who other staff were afraid to challenge. There were several family members who worked or had worked together. This had led to a reluctance of staff with concerns to raise them as they felt they may be putting their job on the line. A member of staff spoke about a staff meeting where they were all asked outright if they had raised concerns with an outside agency.
- Relatives told us staff were confrontational when they raised legitimate concerns at people's reviews. A relative commented that a member of staff was very aggressive, very rude, very defensive, and raised their voice. They stated similar concerns were raised at each review with no improvement in care.

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

characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had completed questionnaires with people to gather their views of the service provided. However, there was no evidence of any analysis of the survey results, or any action taken to improve care.

● There was no evidence to show the provider had acted in line with their duty of candour when incidents happened in the home. For example, there was no evidence families or social workers had been contacted when people raised concerns over possible abuse.

Continuous learning and improving care; Working in partnership with others

● The provider had not kept up to date with national policy to inform improvements to the service. For example, there was no evidence of them working to reduce the use of medicines to improve people's lives. Additionally, the provider had not invested in staff by providing them with quality training to meet the needs of all individuals using the service. A member of staff told us, "The problem with online training is you can skip to the questions and wing it." This meant staff were not always aware of how to provide care which met national policy.

● There was a lack of reflective practice or analysis of the incidents within the home. This meant opportunities to identify learning was missed. As staff were not identifying where their practice could improve it led to a culture in the home that people were just aggressive and would become distressed and need restraining.

● As noted earlier in the report staff had failed to follow healthcare advice to support people's needs. The lack of documentation to reflect people's current needs meant healthcare professionals might not get all the relevant information needed to support improvements in care.

Systems had not been established to assess, monitor, and mitigate risks and improve the quality of care provided to people. This placed people at risk of receiving a poor service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not planned to keep people safe or in line with best practice. People's communication needs were not met and activities were not provided to support people's need.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured there was a culture where people's independence was respected and they were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's ability to make decisions for themselves were not assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were safeguarded from abuse. Staff did not raise concerns with the local safeguarding authority.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor the quality of care provided or drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were enough staff to meet people's needs. Staff did not receive training and support to ensure they could provide safe care, in line with national guidelines , to people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been identified and care was not planned to keep people safe. Medicines were not safely managed.

The enforcement action we took:

We imposed conditions on the provider to improve their management of risk and medicines.