Achieve Together Limited

Tamarisk 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
Tamarisk House is a residential care home providing personal care and support to up to five people with a learning disability and or autistic people. At the time of our inspection there were five people using the service. The service consisted of one large bungalow, with shared communal spaces, and each person had their own bedroom with en-suite bathrooms.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support: The standards of care provided, did not support people to have choice and control over their own care and lifestyles. This was compounded by the level of staff available to meet people's assessed needs, and to give them regular access to the community. Adherence to guidance and provision of equipment by health care professionals needed to be implemented into practice to ensure people received the correct levels of dignified care and support.

Right care: People were not always supported to have maximum choice and control of their lives. Staff did not always 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. Gaps in staff training and competency checks did not ensure staff had the necessary skills, knowledge and expertise to safely meet people's needs. Care records did not demonstrate people were involved in the development of these documents, or that their individual wishes and preferences were consistently reflected.

Right culture: With no registered manager, there was a lack of leadership within the service. Members of the provider team visited the service but did not complete meaningful records to support ongoing improvement of the service. Inspection findings highlighted that where shortfalls were being identified, timely action was not being taken to address these and make improvements to the quality of people's care or the condition of the care environment. People were not being empowered to lead meaningful lives, or to be part of their local community in line with the provider's own Right Support, Right Care Right Culture position statement.

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

Rating at last inspection

This service was registered with us on 01 December 2020 and this is the first inspection. The last rating for the service under the previous provider was Good, published on 06 July 2019.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and people's quality of life at the service. A decision was made for us to inspect and examine those risks. We found evidence during this inspection that people were at risk of harm from the concern. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement and Recommendations
As an outcome of our first day of inspection, we served an urgent letter of intent to the registered provider, under Section 31 of the Health and Social Care Act 2008. This required the registered provider to give written assurances of the action they would take in response to the serious risks and concerns we identified, as well as timescales for issues to be addressed. We completed a second inspection to determine if sufficient action had been taken by the provider to improve and maintain people's safety and welfare.

We have identified breaches in relation to person-centred care, consent, safe care and treatment including in the use of medicines, staffing and good governance and oversight of the service at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 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**

Care Quality Commission

Tamarisk 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
On the first day of inspection there was one inspector, and one specialist medicines inspector. On the second day of inspection, there was one inspector and one inspection manager.

Service and service type
Tamarisk House 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. Tamarisk 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
Both inspections were unannounced, and the second inspection was completed out of hours.

What we did before the inspection
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 sourced feedback from the local authority and used information we held about the service on our system, this information was all considered as part of the inspection planning process.

During the inspection
We spoke with four members of care staff, one agency staff member and two regional managers. After our first inspection visit, we liaised with the nominated individual in the absence of a registered manager. (The nominated individual is responsible for supervising the management of the service on behalf of the provider).

We reviewed a range of records, including five people's care and medication records. We looked at 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 spoke with one person's relative by telephone, about their experiences of the care provided. We sourced feedback from health and social care professionals who had regular contact with the service, and with people's relatives. We liaised with the local authority quality assurance team, and made onward referrals to external agencies, including Norfolk Fire and Rescue Service.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this service under a new registered provider. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
● Risks to people were not well managed. Staff were not using moving and handling equipment provided by healthcare professionals and we observed staff to use poor moving and handling techniques that put people at risk of harm.
● Items which posed a potential risk to people living in the service were not stored securely, including cleaning and personal care products. There was a known risk for one person of consuming hand sanitiser.
● Care records were not being updated following incidents and accidents. Care records were of poor quality, and it was difficult to determine if information was current, as not all had been dated. Staff told us they had limited time available to be able to make the necessary updates, on top of their daily care responsibilities.
● Concerns regarding building security and people's safety was identified. This included missing gates at our first inspection, and then installed gates with no locks on our second inspection, leaving the garden unsecure.
● Taps and sinks were found to have limescale present, which posed an infection control risk. Surfaces within high use areas of the service, such as bathrooms and bedrooms were damaged. This impacted on the staff being able to keep the service clean and increased the risk of the spread of infection.
● Outside areas of the service were in a poor state of disrepair. The garden was uneven and contained hazards. This did not offer people an accessible or user-friendly space to enjoy.

Risks relating to the health and welfare of people were not assessed and managed. 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 managed safely. One person had out of date medicine. This medicine had continued to be used by staff. This risk was only identified as an outcome of our inspection. This did not demonstrate staff were completing required safety checks before giving people their medicines.
● We found one instance where a person was prescribed liquid and tablet forms of the same medicine, the records looked like the person had been given over their prescribed amounts of medicine. As an outcome of these findings, we asked the provider to investigate this and take steps to reduce the risk of reoccurrence.
● Staff were not always following the instructions for use of as required medicines (PRN). Records did not demonstrate that people were given PRN medicines to aid pain management, ease constipation or support changes in their presentation.
● Risk assessments were not in place where people used paraffin-based skin products. The provider had not identified the associated fire risks for people. At our request, the provider implemented risk assessments

and amended people's Personal Emergency Evacuation Plans.
● Medicine risk management plans were not person-centred. We found documents contained the same person's name in multiple people's documents.

Risks relating to the management of people's medicines and the associated risks were identified. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was admitting people safely to the service.
● We were not assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider was meeting shielding and social distancing rules.
● We were somewhat assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.

Risks relating to the health and welfare of people were not assessed and managed, including a lack of adherence to procedures to prevent the risk of the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● Relatives were able to visit and spend time with people inside or outside the service. Some people went out in the community with their relatives.

Staffing and recruitment
● People were not being protected from harm. Required pre-employment safety checks where risks and concerns were identified had not been completed in detail, to ensure that staff were appropriate to work within care settings.

Required checks in relation to character, and suitability to work within a care setting were not in place. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been a large number of staff who left the service recently, and suddenly. Staff and relatives told us this lack of familiarity had had an impact on people, and the care provided. Agency staff were being used, but were unfamiliar with people and their relatives when they contacted the service. This did not offer people a consistent and predictable atmosphere within their own home.
● Staffing numbers impacted on their levels of oversight of people. Inspection findings identified that a lack of staff on shift, resulted in a person requiring staff supervision in the kitchen to maintain their safety used the kettle unsupervised, and a person requiring supervision when eating was left alone, increasing their risk of choking.
● There were not enough staff on each shift at night time to safely meet people's assessed needs. Whilst improvements to night-time staffing were made as an outcome of our inspection, day-time staffing levels still impacted on the level of one to one support people received.

● People were not receiving their funded levels of one to one care and support, due to poor staffing levels. Consideration had not been given to the impact this had on people's safety and wellbeing.
● Staffing numbers during the day, and particularly at night-time, had not been considered in relation to the management of emergency situations, such as needing to evacuate in the event of a fire, and only changed as an outcome of this inspection.
● The provider's own fire risk assessments identified the need for more than one staff member to support people to evacuate. Records also showed, once evacuated, people could not be left alone. Staffing levels, particularly at night-time did not meet this assessed risk. Until this inspection, there had only been one staff member on shift at night-time.

Sufficient levels of staff were not in place to keep people safe during the day and overnight. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Lessons learnt were not shared with staff. Provider level oversight of the service was poor and did not ensure consistent standards of care were being maintained in the absence of a registered manager. There was no evidence to demonstrate how lessons had been discussed, reflected on or learnt from as an outcome of previous incidents that had happened at the service.
● Some of the areas of concern found during this inspection had already been identified through the provider's own quality audits, and from a recent local authority assessment. Our inspection findings did not demonstrate that the provider took a proactive approach to learning lessons or implementing changes in response.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse. We observed an example of restrictive practice used by staff, which was not clearly set out as a suitable approach in the person's care records. Staff were at risk of using punitive approaches, rather than least restrictive options.
● We made referrals to the local authority safeguarding team as an outcome of this inspection.
● Staff demonstrated an understanding of safeguarding processes; however, the lack of provider level oversight did not ensure that poor practices within the service were being identified and acted on in a timely way. Staff told us they were left to make decisions without sufficient support and oversight from the provider.

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.

This is the first inspection of this service under a new registered provider. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.
● Staff were not working within the principles of the MCA. Staff were unfamiliar with which people living at the service had an authorised DoLS in place. This lack of awareness was demonstrated by the environmental security concerns found during this inspection. We observed gardeners to visit, and leave all gates open, and the door to the garden was unsecured due to a broken handle. Additional risk assessments to keep people safe in line with their DoLS had not been considered.
● The provider's own audits and checks had not identified that the wrong address details were listed on one of the person's DoLS authorisation forms. This did not ensure the DoLS was authorised correctly.
● Assessments of people's capacity were not kept under regular review to ensure that staff captured where people's abilities and understanding was changing.
● Guidance documents in place, for example, explaining to people that they should not enter other people's bedrooms and consume personal care products were put in place after the inspection. However, these documents did not demonstrate staff had assessed or considered the person's capacity and abilities to understand the material correctly.

The provider was not working in line with principles of the MCA and DoLS frameworks. This was a breach of regulation 11. (Need for consent) 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
● Staffing levels impacted on people's choices and access to individualised care. Staff told us that where there were low numbers on shift, or a lack of drivers, this impacted on people's abilities to access the local community and other activities. This was reinforced by inspection findings as we observed people waiting a long time for example between getting up, and then leaving the service to go out for a planned activity. Activity records showed people were regularly remaining at the service, and not engaged in meaningful inhouse activities.
● Records gave examples of where a person's community activity was a visit to the pharmacy to collect prescriptions, and a coffee while out. This did not demonstrate meaningful, personalised activities were considered and tailored to the person's own wishes.
● Inspection findings did not demonstrate that the service was meeting some of the underpinning principles of Right support, right care, right culture. The provider's position statement said, "Achieve together interventions focus on inclusive communication and ensuring that where people display behaviours of concern, interventions are person-centred and least restrictive." However, inspection findings did not demonstrate this approach was being implemented by staff in their practice and approach to the care provided.

The provider was not ensuring that people received personalised care, tailored to their individual choices, needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff skills and training did not always meet people's needs. We identified gaps in staff training records. This was of particular concern in relation to those staff responsible for the day to day running of the service and oversight of the staff team to ensure they had the required skills and knowledge to lead by example within the team. Where staff had completed training, they did not consistently demonstrate this was implemented into their practice.
● Staff did not always demonstrate their understanding of the specialist support required for the people living at the service, particularly in relation to individual communication needs, or understanding and interpreting people's body language and non-verbal communication. We observed people to regularly attempt to engage with staff, but these social cues were overlooked as the staff were busy.
● Agency staff confirmed that they had an induction and spent time with an experienced member of staff, and we observed them being shown around the service.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were not always supported with their diet or health conditions in a safe way. One person was not being supported to eat and drink safely in line with the professional guidance in place. We identified examples of incorrect food consistencies being given to the person, placing them at increased risk of choking.
● Systems in place to monitor people's food and fluid intake lacked accuracy. For example, we observed lunchtime on the first day of inspection, and items such as pieces of fruit had not been recorded as given to people in their records, when we had observed this to be the case.
● Staff were not recognising where people's abilities or health conditions had changed, and they required a review. There were environmental limitations within the service impacting on the level of support that could be provided.
● We identified that where people had received involvement from healthcare professionals, the guidance

and equipment provided was not being followed. This did not ensure people were being kept safe.
● There was limited evidence of involvement by people in meal planning, however we did observe people to be offered choices at lunchtime. Food was mainly cooked from scratch, and people had access to fresh fruit throughout the day.

Adapting service, design, decoration to meet people's needs
● The service design did not always meet people's needs. There was a lack of storage for large items which resulted in boxes and bags being stored on top of people's wardrobes, or on the floor reducing the amount of available space and increasing the risk of falls associated with environmental hazards.
● The care environment did not contain signs for example to assist people to orientate to where the bathroom, or their bedroom was located.
● People's bedrooms were personalised in their decoration and content. This included meaningful items such as photographs and items of individual importance.

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.

This is the first inspection of this service under a new registered provider. This key question has been rated 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
● People were not living in an environment which was caring and nurturing, to support them to achieve positive care outcomes, and lead meaningful lives.
● People were not always supported in the way they preferred. From reviewing people's daily records and observations of care, people were not involved in purposeful in-house activities and engagement with staff. This again linked to the ratio of people to staff on shift.
● People had choice over how they wished to decorate their bedrooms, and what clothes they wished to wear, as an expression of individuality. However, improvements to the condition of the care environment were needed to make this more accessible, particularly the garden.
● Staff were mainly caring, but their abilities and at times understanding of people's needs did not ensure the care provided was consistently person-centred. This resulted in more task-based care being provided.
● We observed a staff member taking a restrictive practice approach when a person was showing signs of distressed behaviour, rather than implementing supportive measures in line with personal, behavioural support planning.

Respecting and promoting people's privacy, dignity and independence
● Staff did not always respect people's dignity and independence. Staff were mainly observed to knock before entering people's bedrooms and explained what they were going to do while supporting people. However, poor moving, and handling techniques used by staff did not ensure a person's dignity and independence was maintained.
● We observed staff discussing the timing of people using the toilet, in front of other people living at the service. This approach to timing people to use the toilet felt institutionalised, rather than person-centred. Staff also loudly discussed people wishing to use the toilet in front of others which was not respectful of people's privacy and dignity.
● Staff told us they were expected to get people up in the morning before the day staff arrived on shift. This resulted in two people being up before 6am. The people's care records did not reflect if this was their own choice to get up early.

Supporting people to express their views and be involved in making decisions about their care
● People were not always supported by staff to express their views. There was a lack of time available for staff to source meaningful feedback from people. This was of particular concern where people found it harder to ensure staff understood their needs and wishes.
● Examples of questionnaires completed by people with support from staff were used by the service to

source feedback. However, these forms were completed by staff working within the service, therefore did not offer the option to offer feedback anonymously, or impartially.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this service under a new registered provider. This key question has been rated 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; 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 care records were not always personalised to meet their needs. Care records did not contain evidence of people or their relatives being consistently involved in the planning and decision making relating to their care and support needs, wishes, aspirations and preferences.
● Care records lacked meaningful, personal goals to maximise people's levels of choice and control over their lives.
● Care records did not contain detailed guidance for staff, to support them in their interactions with people. For example, to help them understand people's methods of communicating their thoughts and feelings.
● Use of agency staff posed an additional risk for those people with limited communication to ensure their needs were recognised and met.
● Staffing levels and pressures on their time impact on people's access to one to one care and support. This did not offer people opportunities to discuss their needs and wishes with care staff.

The provider was not ensuring that people received personalised care, tailored to their individual wishes, needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 always supported to follow their interests. Staffing levels, and a lack of staff who could drive impacted on people's levels of community activity. If people required support to access the community, then staffing numbers needed to be increased to ensure those people remaining at home could also be kept safe.
● Where activities had been arranged, and staffing levels changed at short notice, risk assessments were not kept under review to determine if proceeding with a trip out, and the level of staff left on site was sufficient to safely meet people's individual needs.
● On our second day of inspection, two people were due to go out with a member of staff. They were due to go out at 9.30am, and were up early, but had not gone out by 11.30am when we left the inspection. This did not support the management of people's expectations.

● People were supported to send relatives celebration cards, and presents, and to maintain regular contact using comfortable methods such as telephone and face to face visits.

Improving care quality in response to complaints or concerns

● From reviewing the relative survey feedback completed in 2021, the main concerns identified related to the condition of the outside of the service, however, improvements had not been made to the garden and outside areas of the service when we inspected.

● The lack of provider level oversight, along with a lack of regular staff meetings, did not ensure that lessons were learnt as an outcome of any complaints or concerns received from people or their relatives. This in turn, did not ensure standards of care provision were being improved.

End of life care and support

● There was no one receiving end of life care at the time of the inspection.

● Few care records contained end of life planning, or evidence of consultation with people and their relatives. Records did not demonstrate this area of people's care was regularly reviewed with people and their relatives to encourage open conversations and forward planning.

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.

This is the first inspection of this service under a new registered provider. This key question has been rated 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; 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

● Poor standards of recording, a lack of provider level oversight and quality auditing, had not identified areas of concern found during this inspection, including use of restrictive practices, non-adherence to healthcare professionals guidance, and poor communication standards between people and staff. This was resulting in poor care outcomes for people living at the service.

● Where members of the provider team visited the service, reports of the audits and checks completed, and any corresponding action plans were not given to staff as an outcome, to support change and improvement. Staff told us they needed more guidance to support implementation of changes between provider level visits.

● The day to day running of the service, and many of the audits and checks were being designated to staff, who had limited time to be able to complete them in detail, but also were not in receipt of additional training to ensure they had the required skills and competence in place.

● Based on feedback received, and inspection findings, lines of communication between the registered provider and the staff at the service, and with people's relatives needed to improve. We were given examples of where relatives felt they were not kept well informed when a person had an accident and subsequently was admitted to hospital for surgery.

● Poor oversight of staff training and competency checks did not ensure that the provider could be confident staff understood how to meet people's needs and individual risks.

● The records in place for the monitoring of accidents, incidents and safeguarding referrals were held centrally, with a lack of communication between the provider and service on findings from the completion of audits to monitor for trends and themes. This also did not ensure the provider had systems in place to check all notifiable incidents were being reported appropriately.

● In the absence of a registered manager, staff had been left to run the service without sufficient oversight and guidance. The registered provider had failed to ensure there were arrangements in place to monitor poor performance.

● The last registered manager, de-registered in December 2021, and there had been changes in staff leading up to the time of this inspection. This did not ensure that staff, people and their relatives had access to consistent leadership, or that changes were embedded in practice.

The provider had poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff were not providing high standards of care and were not working in line with the provider's own Right support, right care, right culture position statement, which said, "[We are] an organisation who provide specialist services which deliver consistently great outcomes for people with learning disabilities and autism."
- We observed the care provided was task focussed rather than person-centred, and a lack of provider level oversight of the service did not ensure that people were being empowered to lead meaningful lives as part of their wider community. Care records did not demonstrate regular involvement from people and their relatives into the planning of their care.
- Due to a lack of oversight of the service, the provider did not have a good awareness of people's quality of life and were not ensuring in the absence of a registered manager, that standards of service provision were being maintained.
- The lack of regular staff meetings did not offer opportunities to provide feedback or make suggestions on areas the service could improve. Staff gave examples of concerns they had repeatedly escalated to previous managers, but no action had been taken in response.
- Lessons had not been learnt from recent local authority assessment findings, or ongoing support provided by external stakeholders.
- Where the service was working with other professionals, we identified the staff were not then implementing guidance, or equipment into their practice to maximise people's levels of independence and safety. Where feedback was sourced from people's relatives, this was not being acted on, for example to improve the conditions of the garden and outside areas of the service.

The provider had poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) 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 The care provider was not always providing person-centred care in-line with people's wishes and preferences. People did not have access to regular, meaningful activities. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) (h) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not always working within the principles of the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards. Regulation 11 (1) (2) (3) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The care provider had not ensured required checks in relation to character, and suitability to work within a care setting were completed before staff commenced employment. Regulation 19 (1) (a)

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 The care provider did not always ensure that people and the care environment were consistently kept safe. Risks to people were not always well managed, including with medicines management and infection prevention and control. Regulation 12 (1) (2) (a) (b) (g) (h)

The enforcement action we took:

Conditions imposed at this location, on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not always have good governance and leadership in place. Audits and quality checks were not consistently identifying risks and shortfalls. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Conditions imposed at this location, on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider was not always providing person-centred care in-line with people's wishes and preferences. People did not have access to regular, meaningful activities. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) (h) (5)

The enforcement action we took:

Conditions imposed at this location, on the provider's registration.