IBC Quality Solutions Limited

Tarry Hill

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Tarry Hill is a care home in the New Mills area of Derbyshire. The home is made up of five separate houses in one communal setting. The home is registered to care for up to 26 younger adults and people with learning disabilities and autistic spectrum disorder and older people. At the time of the inspection there were 18 people living there.

The service had been developed and designed before the principles and values that underpin Registering the Right Support had been published. This guidance aims to ensure 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. The service was larger than current best practice guidance.

People's experience of using this service and what we found
The service was not safe. People were subject to excessive control and restraint. Staff and managers had not recognised and taken action in relation to safeguarding incidents and potentially abusive practices. The use of physical intervention and restraint was not assessed or planned for and staff did not have appropriate training to enable them to perform physical intervention safely. Staff had been harmed as a result of poor behaviour management. Opportunities to learn from adverse incidents had been missed.

Environmental risks were not managed safely and the environment was not clean and hygienic. Medicines were not always safely managed resulting in some people getting too much or too little medicine. There were not always enough staff to ensure people's safety in the event of an incident. Safe recruitment practices were followed.

People's rights under the Mental Capacity Act were not upheld. People were not always supported to have maximum choice and control of their lives and 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 always support this practice. Staff had not received the training they needed to complete their role safely and effectively. People's support was not always provided in accordance with national standards or good practice. The environment was adapted to meet people's needs.

People were not always treated in a dignified way. Feedback about the approach of staff was mixed. There was a lack of consistency in the quality of support people received. Several staff expressed concern about some people's wellbeing and told us they were unable to provide appropriate support to some people. The approach to promoting people's independence was inconsistent. People and their relatives had been involved in developing parts of their support plans.

People did not consistently receive personalised care that met their needs. People were not always provided with opportunity for meaningful activity. There were systems to manage complaints but some relatives told

us they had to chase up a response to their complaints or concerns.
Tarry Hill was not well led. The provider did not have effective oversight of the home. Consequently, there had been a failure to identify and address serious issues with the safety and quality of the service. Systems to monitor and improve the quality of the service were not effective. Where audits had identified areas for improvement, action had not been taken to address issues. The provider had not implemented learning from serious incidents. Failings in leadership and governance placed people at risk of harm. The provider was not always open and transparent and did not always meet the duty of candour.

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 Requires Improvement (published November 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to gaining person centred care, dignity and respect, consent, safe care and treatment, safeguarding people from abuse and improper treatment, good governance and staff training.

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. 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 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 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?

Inadequate

The service was not Safe.

Details can be found in our Safe findings below.

Is the service effective?

Inadequate

The service was not Effective.

Details can be found in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details can be found in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details can be found in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not always well-led.

Details can be found in our Well-led findings below.

Tarry Hill

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
This inspection was carried out by inspectors and one specialist advisor who was a learning disability nurse. A second day of inspection was completed by two inspectors.

Service and service type
Tarry Hill is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 on both days.

What we did before the 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. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information that had been sent to us by staff and visitors to the service. We sought feedback from the local authority commissioning and safeguarding teams. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with 15 members of staff including the area manager, implementation manager, registered manager, deputy manager, senior care workers and care workers.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two 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
After the inspection we continued to seek clarification from the provider to validate the evidence found. We spoke to more staff, six relatives and a range of professionals who regularly visit the service. We asked the provider to take action to protect some of the people who lived at the home from potential harm. We shared our concerns with local commissioners and safeguarding authorities to ensure there was a review of some people's current care.

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 Requires Improvement. At this inspection this key question 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

- Some people were subject to excessive control and physical intervention. Physical intervention, including restraint was regularly used at Tarry Hill. Staff told us that as many as six staff had held people in floor holds when their behaviour escalated. Being held down by multiple staff poses a significant risk to people's physical and psychological well-being. This deprivation of their freedom was not lawfully authorised.
- Punishments, such as sending people to their bedrooms to 'think about' their actions were used to manage some people's behaviours. This form of behaviour management did not respect people's rights and created a culture where staff had power over people.
- People had suffered emotional distress as a result of witnessing incidents of aggression by others and physical intervention by staff. For example, one person had started harming themselves at these times. Staff told us they were concerned people's well-being.
- Staff and managers had not recognised and taken action in relation to safeguarding incidents and potentially abusive practices. For example, an incident where a person was restrained using unauthorised and unsafe techniques which had resulted in them falling between their bed and the wall had been witnessed by the registered manager. It had not been investigated or referred to the local authority safeguarding adults team. This meant no action had been taken to reduce risk or protect people from further harm.

The provider's failure to protect people from abuse and improper treatment was a was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The use of physical intervention and restraint was not always assessed or planned for and staff did not have the correct training to enable them to perform physical interventions safely. They used advanced physical intervention techniques, but none of the staff had this level of required training.
- Some people's behaviour support plans did not contain information about what physical intervention technique could be used to ensure their safety or staff's. Furthermore, there had been no consideration of individual health condition when using restraint. This had resulted in unsafe practices that placed people at risk of injury. Records showed a person with a health condition had been restrained in a way that could have caused them injury.
- There were insufficient plans to manage crisis situations. Although behaviour support plans were in place, for some people, which detailed triggers to behaviour and indicators that a person was entering crisis they lacked specific detail about what staff should do in these situations. Some staff we spoke with were not able to explain what actions they would take in emergency situations to protect people.
- Staff had been harmed as a result of poor behaviour management. Several staff told us they had been

assaulted, some seriously, by people they supported. Despite this no action had been taken to review behaviour management strategies. This meant staff remained at risk.
● People were at risk of injury from bed rails. One person had bedrails in place, there were no protective bumpers in use and no risk assessment had been completed. This person had regular seizures so there was a risk of them injuring themselves on the bed rails. Furthermore, no assessment had been made to judge whether the person could injure themselves trying to get over these rails. There were also no regular checks to ensure they were safely fitted to reduce the risk of entrapment.
● Environmental risks were not managed safely. Some aspects of the environment posed a risk to people. For example, one person was at risk of harming themselves on sharp objects, we saw screws with sharp edges sticking out of a door in their bedroom. This posed a risk the person may harm themselves.

Preventing and controlling infection
● The environment was not clean and hygienic. Some areas of the home were in a poor state of repair which meant they could not be cleaned properly. For example, we saw bodily matter encrusted on a door fitting.
● Other parts of the home such as fridges used to store food, were in an unhygienic state and some areas were odorous.
● This posed a risk to people's physical wellbeing.

Learning lessons when things go wrong
● Opportunities to learn from adverse incidents had been missed. There had been a lack of robust investigations and lessons learned when things had gone wrong.
● For example, where a person had been subject to physical restraint, the provider and registered manager had failed to thoroughly investigate this incident and ensure people and staff were protected from avoidable harm in the future.

Using medicines safely
● Medicines were not always safely managed.
● We found two medicine errors that had resulted in people being given too much or too little medicine. Staff had documented the error but there was no evidence that action had been taken to ensure people's immediate wellbeing or to reduce the risk of this happening again.

The provider's failure to provide safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff to ensure people's safety in the event of an incident. Our concerns were primarily related to night shifts.
● For example, staff told us there were times when up to six staff were needed to restrain a person. Despite this there were only three members of staff on at night in this part of the service. In another part of the home, four staff had been required to intervene when a person's behaviour escalated. There was only one member of staff on shift at night in this part of the home.
● There was no risk assessment or contingency measures in place detailing how the person's behaviour should be managed at night time.
● This failure to ensure enough staff were deployed placed people and staff at risk of harm.

The provider's failure to ensure there were enough, suitably qualified staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Staffing levels during the day were in line with the levels determined as safe by the provider.

● Staff were safely recruited. They had undergone an application process, interviews and been subject to pre-employment checks including enhanced criminal records checks.

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 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.

- People's rights under the MCA were not always upheld. Where people had been deprived of their liberty, conditions imposed upon their DoLS had not been followed. For example, one person's DoLS stated that seclusion could be used in specific circumstances, provided staff observed the person closely. However, the person was secluded for long periods of time with no rationale recorded and staff were unable to observe the person to ensure their safety. This did not respect the person's rights and was not in line with national guidelines.
- There was no evidence that less restrictive options had been considered when managing people's behaviours. For example, records showed staff frequently use restraint without consideration of alternative, less restrictive options. These incidents were not routinely reviewed to determine what alternative approaches could be put in place in future.
- Staff did not have a consistently good understanding of the MCA and DoLS. One staff member said, "I don't really understand what DOLS is about." Some staff demonstrated they did not know the conditions on a person's DOLS whilst they were supporting this person. This meant they lacked the knowledge to ensure people's rights were respected and they met the legal requirements of the authorisation.

The provider had failed to act in accordance with the Mental Capacity Act. This is 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

● Staff had not received all the training they needed to provide safe and effective care. Staff did not have adequate training in the use of physical intervention. This had resulted in them using improvised techniques to manage people's behaviours. This placed people and staff at significant risk of injury.

● The lack of training and consequent risk was reflected in staff feedback. One staff member said, "The training is totally insufficient compared to the level of violence some people show us." Some staff told us they feared for the safety of other staff and people living at Tarry Hill.

● The provider had failed to check if agency staff had received training in the safe management of behaviour.

● Staff told us they did not always feel supported at work. They gave examples of returning to work after serious incidents with no effective de-brief. This had a negative impact upon the wellbeing of staff.

The provider's failure to ensure staff were trained and supported was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's support was not always provided in accordance with national standards or good practice.

● There had been no analysis, or assessment of the function of people's behaviour. This meant staff lacked adequate understanding of why people behaved in certain ways and were not able to reduce the triggers to people's behaviour.

● Although care plans contained some guidance for staff, behaviour management plans were not based upon best practice and there was a lack of guidance about how staff should respond to crisis situations. This had resulted in poor behaviour management practices which were not in line with national guidance.

The provider's failure to fully assess people's needs and provide person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People told us they enjoyed the food provided. We saw that people ate what they chose when they chose.

● Relatives told us the food provided met the needs and preferences for their relation. One relative said, "Mealtimes are a lovely community feel, people eat together if they want to."

● Some food storage areas were not clean, a fridge used to store culturally specific food was dirty and could have led to cross contamination.

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

● Staff had a limited understanding of professionals involved in people's care and referrals to specialist health professionals had not always been made when people's behaviour changed.

● Feedback from relatives about support for people's physical health needs was positive. One relative told us that staff had gone the extra mile to make sure hospital appointments were more person centred for their relative. They said, "Staff have arranged for the doctor to visit [Name] in a way that [Name] feels happier and calmer, that is amazing."

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

● People and their relatives had been involved in decisions about the design and decoration of the premises. One person's bedroom had been designed to look like their bedroom in their family home.

● In contrast some people's bedrooms were sparse and did not contain any personal belongings and had not been personalised. Staff told us this was due to risk. This had resulted in these bedrooms feeling

institutional and impersonal.

● The buildings had been designed so people could maintain their privacy and have their own personal space when they wanted this. This included outside areas. However, staff told us that in one area of the home people had stopped using a communal room due to the behaviour of another person. This meant the communal space they could use was limited.

● During the inspection there was some maintenance work being carried out to the external grounds. This was managed in a way that did not cause distress to people living there.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● People were not always treated well. Throughout our inspection we found evidence that indicated a culture where staff had power over people. The frequent use of restraint, seclusion, and punishment imposed by some staff led us to be concerned for people's physical and psychological wellbeing.

● Feedback about the approach of staff was mixed. The majority of people told us they were happy at Tarry Hill. However, some people said they were not happy and expressed concerns about how staff treated them.

● There was a lack of consistency in the quality of support people received. Whilst we observed many positive interactions between people and staff, we also saw instances where staff talked amongst themselves and were not attentive to the people they were supporting. For example, one person had three staff monitoring them and sitting outside their room without any identifiable reason as the person was not distressed. This did not uphold their right to privacy.

● Some people did not have access to their personal belongings for lengthy periods of time. Staff told us this was due to potential damage which could be done to property. This did not uphold their dignity.

● Some staff knew the people they supported very well and showed an in-depth understanding of what mattered to them and the support they needed. Other staff had a limited understanding of the people they supported and appeared to be present in a supervisory capacity only.

● Several staff expressed concern about some people's wellbeing and told us they were unable to provide appropriate support to some people due to their struggle to manage the behaviour of others. This had a negative impact upon the quality of care these people received.

The provider's failure to ensure all people were treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The approach to building people's independence was inconsistent. Some people had achieved levels of independence that had not previously been possible for them. We saw people who had previously not been able to go out, now enjoyed time out of the home. One relative said, "[Name] has achieved things they've never achieved before, this is massive and it's all down to the staff." However, this was not the case for everyone. For example, records showed some people had limited contact with staff and no structured plan for building their independence.

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

● People's care needs were reviewed, and people were involved in the reviews. At times where people and relatives or advocates disagreed with the views being expressed, staff took time to help all involved see things from each other's perspective.

● People and their relatives had been involved in developing parts of their support plans. In some cases, people had written sections of their care plans themselves. However, this did not include physical intervention.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

- People received inconsistent support. Staff told us the support people received depended upon the individual staff members. A member of staff spoke of one person and said, "Some staff just let [name] do what they want because it is easier. That makes it harder for other staff who are trying to maintain boundaries." They told us this had a negative impact upon the person's anxiety and resultant behaviour.
- Staff did not have adequate guidance about how to reduce people's anxiety and distress. Some people, including those who had frequent periods of anxiety and resultant behaviour, did not have a behaviour support plan place. This meant staff did not have any guidance about triggers to people's behaviour or how best to support them.
- People did not always receive personalised care. Some staff told us that the frequency and intensity of people's behaviours and staffing levels meant that some people did not get to do the things they wanted to do, such as going out in the community.
- Where people used their behaviour to communicate, this had not always been fully explored. For example, records showed, one person had frequent, almost daily, incidents resulting in their behaviour escalating. Staff told us this was random and unpredictable. However, there had been no analysis of factors such as time of day, staff involved or environmental factors leading up to the incidents. This meant opportunities to understand what people were trying to tell staff with their behaviour had been missed.

The provider's failure to consistently provide person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- The service was meeting the AIS. People's communication needs were explored, and documentation was provided for them in a format they could understand.

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

- In contrast with the above, some people were supported and encouraged to take part in activities that were socially and culturally relevant and appropriate to their needs and preferences. Some people enjoyed full and active lives and took part in their preferred activities throughout the day and evenings.

● Some people were supported to access and be part of the wider community. These people were not restricted to visiting places limited to people with learning disabilities.
● Relatives told us they were welcomed and had no restrictions placed on their visiting times. This meant that people were supported to maintain relationships that were important to them. one relative told us, "They always accommodate me, we eat together, and I help with [Name's] support needs, it's important to us that I am still a part of their life."
● Some people were supported to achieve goals and do things they had always wanted to do. For example, people went on holidays, one person had been helped by staff to fundraise for a holiday to Nepal. This was something they had aspired to do, and staff celebrated this achievement.

Improving care quality in response to complaints or concerns
● People were empowered to raise complaints if they wished to. There was guidance within their care plans and around the service which guided people how to make a complaint. These were designed in formats that people could understand.
● We reviewed the documented complaints and saw that these had been handled as per the provider policy. However, some relatives and staff told us that if they raised a complaint they didn't receive an answer or had to chase the management to reply to them.

End of life care and support
● The service did not support people who were known to be approaching the end of their lives. However, the registered manager had ensured people's end of life or serious illness wishes were explored and where appropriate, families were involved in these discussions. Where people or families had declined to have this conversation, their wishes were respected.

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 has deteriorated to inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- During our inspection of Tarry Hill, we found widespread and significant shortfalls in the way the service was governed. There had been a lack of effective leadership and management.
- There was a culture of acceptance of practices that restricted people's rights. Many of the risks found throughout our inspection, such as physical intervention and seclusion had been overlooked by the management team as they had become accepted as part of the culture. For example, there were incidents the registered manager and other senior staff were involved in.
- There was little focus on reducing restriction and promoting people's basic rights. The provider's vision, to 'deliver high quality care and support enabling individuals to achieve real dreams, goals & aspirations' was not evident for all people living at Tarry Hill. This had resulted in people receiving poor quality, unsafe care.

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

- We had concerns about the practice of the registered manager. Staff told us about the registered manager's involvement in unsafe and inappropriate behaviour management. Records showed the registered manager had reviewed incidents and had failed to identify concerns, make the appropriate referrals and to take action. They were also aware staff did not have the correct training for the physical interventions they were using and had not taken action to rectify this. Consequently, we were concerned that people and staff were at risk of physical and psychological harm.
- The provider failed to conduct robust investigations of concerns about the over use of seclusion. The provider's investigation concluded this was not happening, however, we found evidence to the contrary during our inspection.
- Although most staff understood their role, some told us they did not feel well supported. One staff member said, "When I go to the management team I don't feel I am supported." Another staff member said, "This is the least helpful company I have worked for, staff try their best, but management don't make decisions and that impacts on everyone."

Continuous learning and improving care

- Systems to ensure the safety and quality of care provided at Tarry Hill were not effective. For example, the provider had not identified that staff and people could be at risk from a person whose behaviour was escalating. Consequently, no action had been taken and people and staff remained at risk of harm.

● There was little evidence of learning, reflective practice and service improvement. There was no recent analysis of accidents and incidents. This meant opportunities to reduce risk to people and staff had been missed.
● There was a lack of oversight of the use of restraint and seclusion. Where incidents of restraint had happened, the de-brief completed by the registered manager failed to address how this could have been prevented.
● The provider had failed to take effective action to mitigate serious risks. We wrote to the provider after our first day of inspection asking them to take urgent action to address our serious concerns. However, during our second day of inspection we found continued concerns in these areas.
● Action was not taken to address known areas of concern. The provider had commissioned an external agency to evaluate the service. However, where areas for improvement had been identified there was no recorded outcome or predicted date for the improvements to take place. We found these areas remained of concern during our inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager sent out surveys and questionnaires about the quality of care to relatives. However, some relatives told us that the registered manager was not actively in contact with them and they needed to chase the service for information and updates about their relative.
● Action had not been taken to address concerns raised by staff. Staff told us that due to a lack of training and support, they did not always feel safe at work. Several staff told us they had raised this to the registered manager, but nothing had been done. This lack of action meant staff remained at risk of harm.

Working in partnership with others
● People were referred to external agencies for support. However, in some cases referrals were reactive, rather than proactive, this had resulted in some people only being referred when in crisis.

The provider had failed to ensure the safety and quality of the service, this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 not always adhered to the duty of candour. For example, we identified a series of incidents where a family member had not been informed as required.

The provider's failure to act in an open and honest way with key people was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been a failure to notify CQC of some events within the service, which the provider is required to by law. For example, we found records of a safeguarding incident that should have been submitted to us as a statutory notification. We had not been informed about this. We identified another incident where a statutory notification was submitted to us but did not contain important relevant information and lacked clarity and transparency. This had a negative impact on our ability to monitor the quality and safety of the home.

This failure to notify us of events as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations.

● It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. The provider had displayed their most recent rating in the home and on their website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of all events as legally required. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not consistently provided with person centred care that met their needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the Mental Capacity Act.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 20 HSCA RA Regulations 2014 Duty of candour

The provider did not operate in an open and transparent way.

Regulation 20 (1)