Care Quality Commission

Vivre Care Ltd

Talbot House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Talbot House is a residential care home providing support to up to seven people. The service provides support to people with eating disorders. The service is one of a few specialist care homes supporting people with these conditions across the county. At the time of our inspection there were four people using the service.

The care home accommodates people across three floors in one building. People have their own bedrooms with en-suite bathrooms. There are shared communal spaces such as a lounge, kitchen, dining area and garden.

People's experience of using this service and what we found
Due to the specialist nature of the service provided, during the inspection, we regularly consulted with a number of professional experts in the field of eating disorders and mental health to help guide our judgements. The service had good care outcomes for people but there was a lack of clear and consistent systems to ensure the registered manager had good oversight of the service. This had resulted in inconsistent records, not all risks to people being identified, multiple medicine errors and a shortfall in staff understanding of some of the needs of people being supported. Professional experts in eating disorders agreed this could compromise the safety and wellbeing of the people being supported.

The provider was not registered to support people with learning disabilities or autistic people. However, they were supporting people with eating disorders who were autistic. 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. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People were supported by staff who had received training in eating disorders, treated them kindly and made them feel safe and less worried. The service was clean and well maintained. Regular staff team supported people and there was no need for use of agency staff.

Where people had given consent to do so, their relatives were involved in their care and no decisions about care were made without the person being at the centre of discussions before plans were agreed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported to access all relevant health professionals in order to support their recovery and

ensure their health and wellbeing were being appropriately monitored.

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 14 July 2021 and this is the first inspection.

Why we inspected
This inspection was planned based on the date the service was first registered with the CQC. 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.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines, risk management, personalised care, staff training and support and systems to measure quality at this inspection.

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

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Question	Rating
Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
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 caring. Details are in our caring findings below.	**Good**
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 always well-led. Details are in our well-led findings below.	**Requires Improvement**

Talbot 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.

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. We also consulted with mental health professionals and experts in eating disorders.

Service and service type
Care home name 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. Talbot 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 27 October 2022 and ended on 18 November 2022. We visited the location's service on 27 October 2022.

What we did before the inspection
We reviewed information we had received about the service since it was registered with the CQC. We sought feedback from the local authority, Healthwatch England and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people and (with consent), three of their relatives. We spoke with eight staff including the registered manager, clinical lead, site manager and five care staff. We spoke with two professionals who work with the service.

We reviewed two staff files for recruitment processes and two people's care records. We reviewed a number of other documents, health and safety records and policies.

Requires Improvement

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 newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely
- Not all risks to people had been fully explored and therefore there was a lack of clear guidance for staff about how to reduce the risks. For example, there was no evidence of guidance in place in relation to the risk of aspirating for a person who used a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube. A PEG feeding tube goes directly into the stomach when you are unable to eat or drink. You may need a PEG tube if you have difficulty swallowing or can't get all the nutrition you need by mouth.
- Professional medical experts we consulted confirmed the importance of clear protocols being in place for the support of using a PEG to ensure it is used safely and prevents health complications and infections. Records in relation to changes of meal plans and protocols for the volume of food to be infused through the PEG were inconsistent. The infusion should be checked hourly to ensure there are no concerns. Records showing checks on the infusion simply ticked a box to say checked and did not detail what was checked, such as the infusion rate, volume infused and any signs of infection. The person's care plan did not highlight the need to rotate the PEG or what to do in the event of the PEG tube becoming blocked. Due to the PEG site becoming infected, the person had experienced two recent hospital visits for medical examination and treatment.
- Another example of lack of robust risk assessing was for a person who staff had identified as having 'no road sense' and experiencing sensory overload as they were hypersensitive to noise. There was no risk assessment in place about how to support the person with road safety and sensory difficulties while in the community. The person had experienced on one occasion a distressing situation when a shop alarm was set off as staff had forgotten to ensure the person took their ear defenders with them. We found no guidance about this in their records.
- People who had a history of self-harming such as taking an overdose of medicines had not had risks assessed about how they would be supported to reduce this risk and manage their medicines safely while travelling alone to their family home on visits.
- People's risk assessments and care plans did not offer clear guidance on how people visiting their family homes would be supported with their medicines during this period. While living at the service, this was supported by staff from Talbot House. There were no clear arrangements of working in partnership with local health professional teams to ensure arrangements had been put into place to support people to safely administer their medicines while they were away.
- People's medicines were not being managed or administered safely. Over a period of two months we identified records showing 19 medicine errors. Some errors were related to poor record keeping and others were related to incorrect administration of medicines. Stock counts of medicines were incorrect for one person when we checked them. There were no open dates recorded on medicines and multiple boxes of the same medicine were open and in use at the same time. Medicine Administration Record (MAR) sheets had

handwritten entries that were not counter signed. This was not in line with recommended best practice guidance and increased the risk of further errors and harm to people.
● A nightly audit of medicine stock took place by a support staff. Most errors had been highlighted this way, but some had still been missed. Medicine audits by the clinical lead only took place once an error had been identified. These were not full medicine audits, but an investigative tool used to try to understand how the specific error had occurred. These investigations had not led to a reduction of errors.

Risks to people had not been fully assessed and clear guidance for staff had not been implemented. Medicines were not being safely managed or administered to people. This placed people at risk of harm. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the clinical lead contacted the local authority community pharmacist for support with staff training and to develop safe systems of practice for medicines.

● Despite our findings, people told us they felt their risks had been appropriately assessed. One person said, "Measures are in place for me, I am fully risk assessed".

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● There were systems in place to ensure any safeguarding concerns were reported and acted upon. Staff had received training in safeguarding and most staff had a good understanding of the signs of abuse and how and who to report concerns to. This included reporting to external bodies such as the CQC and the local authority safeguarding teams. However, some staff did not have a good understanding of what various forms of abuse looked like in order to able to identify concerns. They would benefit from additional training in this area.
● People told us they felt safe at the service. One person said, "I feel much safer here than in hospital." Another person told us, "[Staff] are always here. Therefore, I feel safe."
● When an incident or accident occurred, this was reported and recorded and then investigated by the clinical lead. Measures were introduced to try to mitigate future risks and learn lessons from what had happened. This included additional staff training and competency assessments, seeking medical professional advice or reviewing care plans. However, in relation to some incidents such as medicine errors, lessons learnt had not reduced the number of these. The root cause of this was being reviewed by the registered manager and clinical lead.

Staffing and recruitment
● There were sufficient staff on duty to meet the needs of people living in the service. The service did not use agency staff but utilised staff from their other two services to ensure shifts were covered.
● There was a system in place for recruiting staff to ensure their suitability for the role. This included checking they were of good character and completing a Disclosure and Barring Service (DBS) check. A DBS check provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.

- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The provider was open to visiting and with people's consent they were able to have visitors in their home. Realties understood there were some restricted times for visiting such as during protected mealtimes due to the nature of the support required by people to aid their recovery. A relative told us, "[Staff] are lovely people. I go to see my [family member] and they always offer me a cup of tea."

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 for this newly registered service. 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.

Staff support: induction, training, skills and experience
● Some staff we spoke with did not have a full understanding of the risks relating to eating disorders and not all staff had a good understanding of abuse awareness. Most staff we spoke with did not understand autism and how this might impact autistic people being supported in the service.
● From 1 July 2022, the government introduced a requirement for CQC registered services to ensure their staff received learning disabilities and autism training appropriate to their role. For staff required to support people with autism, this should include both an e-learning module with handbook and face to face training.
● Staff told us they did not feel the online training they received had been sufficient and they struggled to know how to support autistic people with their eating disorder and general care needs. This meant there were not enough staff available on each shift who were suitably trained, skilled and experienced to meet people's needs.
● While records showed supervisions being planned, some staff told us they did not feel supported in their role by the management team. They told us they had not received regular supervision. They said they did not feel comfortable to approach the clinical lead for advice as they did not feel listened to and their concerns were not always acted upon. A staff member told us they had never met the registered manager in person and therefore did not feel able to approach them.

Failure to provide sufficient training and support to enable staff to carry out their duties as well as failing to ensure there were sufficient numbers of suitability trained, skilled and experienced staff on shift to meet people's needs was a breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff were being supported to attend further training and conferences for specific areas related to eating disorders.
● Staff said they received an induction which allowed them to read care plans, get to know people and observe practice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service specialised in supporting people with eating disorders. Specific programmes had been designed to support people at various stages of their recovery. People had their needs assessed by external professionals prior to admission to the service. Staff at Talbot House then supported people to access community mental and physical health professionals as required such as clinical psychologists, GPs and nurses. In house, the service was able to provide dietitian, occupational therapist and art and drama

therapist support.
● The information shared by external health professionals was used alongside an 'all about me' form to create a care plan and risk assessments. People told us they were involved in creating their plan of care alongside a team of community health professionals and the staff at Talbot House. However, not all aspects of their assessments such as sensory needs and how historical risks impacted people currently, were fully explored.
● People told us they were supported to view the service prior to admission to make sure they liked it. One person said, "It took a while [because of funding] but then I came and was given a welcome pack." Another person told us, "I am involved in my care."

Supporting people to eat and drink enough to maintain a balanced diet
● People were being supported with meal plans for nutrition and hydration in-line with their individual needs for the stage of their recovery. Meals were an important part of that journey and as such mealtimes were protected. People consented to their food and drink consumption being observed and recorded in order to review progress and assess if adjustments were required.
● Each person had a meal plan that they accepted could be changed if required to meet their nutritional targets. People with specific food requirements due to allergies were supported to choose acceptable options that met their needs. Ready meals were used in order to support people to have options they could choose when living independently that did not overwhelm them. Most people were happy with the meal plans however further improvements could be made to provide fresh food and less reliance on ready meals to enable people to make personalised choices about their meals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People told us they had access to community health professionals and they were appreciative of the support given in house to talk when feeling overwhelmed or worried.
● Staff worked closely with people's consultant psychiatrist and GP in order to review all progress or concerns, medicines, mental health and support. If changes to the care plan were required, this would also be discussed with the person themselves before being agreed.
● People were encouraged to slowly take more ownership of their life and independence was supported. This focused on healthy lifestyles but varied between individual people and the steps they were ready to take. One person told us, "[Staff] look at other physical needs in case you need a specific appointment." A professional said, "I have had regular professional co-operation with the team at Talbot House and have found it easy to communicate with them. They have been responsive and appear to have [people's] best interests at heart."

Adapting service, design, decoration to meet people's needs
● The service was well maintained, clean and tidy. One person's shower was not working and awaiting repair. They were able to use a spare bathroom in the meantime. Staff tried to create a homely environment, but people had consented to some restrictions such as no unsupervised access to the kitchen and CCTV in communal spaces.
● People had their own private bedrooms but also had access to the shared lounge, dining area or garden if they chose to spend time with others. There was a clinical room for one to one support that was separate from the communal spaces for privacy if people needed to talk.
● Equipment such as gas and fire systems were serviced and other health and safety checks maintained to ensure people's safety.

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.

● People had the mental capacity to make their own decisions. They had agreed to the programme at the service in order to support their recovery. This included giving consent to sharing information with other professionals, environmental restrictions, limiting physical activity in order to not over exercise, and agreeing to the prescribed meal plans.
● All restrictions were fully explained to people prior to admission and reviewed. People understood that if they did not agree to the programme and their health was at risk, they may have had to return to a hospital setting for medical supervision and support.
● Where this was the case, the person's mental capacity to understand the risks they placed themselves in was re-assessed by a multi-disciplinary team of health professionals who worked alongside the person. Together, they created a 'best interest/crisis' care plan to help them continue their road to recovery and decide if they were safe to remain at Talbot House.

Good

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 for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us the staff treated them with kindness. One person said, "I was so scared when I first arrived, but the staff are so kind and caring." Another person told us, "I feel listened to, they understand me."
- Staff respected people's different preferences such as requiring specific utensils or comforting objects. People felt the staff were helpful and supportive. One person told us, "It's positive. The longest stay so far for me, I could not stay long in the other places I went before."

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 told us they were involved in all aspects of their care planning. One person told us, "I am involved in any decision, any review." Relatives understood that sometimes their family members did not consent for them to be involved in the care planning process. People told us, staff and relatives respected their decisions about this. Relatives told us they understood the reasons, and this enabled them to focus on their family relationship in a more positive way.
- Where people had given consent, relatives were involved in care planning and informed of any concerns. People also told us there was good communication with the clinical lead.
- People told us staff were approachable and they could talk to them at any time about anything. This in combination with their formal one to one therapy sessions gave them opportunity to let the staff know if there was something, they felt wasn't working for them.
- Relatives told us they appreciated the way their family members felt more independent, which they thought was a positive step in their recovery. One relative said, "I see [my family member] more settled and stable." Another relative told us, "Best service ever. I see [my family member] more independent now and I appreciate that."
- We saw how people were encouraged by the in house therapists to be more involved in group sessions to learn about healthy eating and food preparation. This helped to ready people to be able to cope better in the future as they progressed towards independence and living their lives in the community.

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 for this newly registered service. 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; End of life care and support

● While care plans did reflect person focused and individualised care for people, records in relation to people's goals were not always clear. There were no start dates or details of any progression and review. The guidance was generic about how staff should support people.

● For example, one person was to make contact with local groups to increase social opportunities but there was no record of if this had been done and what the outcome was. Another example was to support a person with 'grounding techniques' but no explanation of what these were or how to use them. For another a person a goal was set to manage their emotions without causing damage to their health. The guidance on how to do this simply focused on not damaging their health in the way they had rather than what alternatives they could try.

● Some preferences such as the need to sleep with a weighted blanket were not incorporated into the care plan providing no evidence that sleep and rest requirements had been assessed. This meant that the records lacked clear guidance for staff around these areas and there was a risk that people received inconsistent support.

● People told us there was not much for them to do on weekends and evenings. They told us they would like to be able to go outside each day even if just for a short time. They also said they would like to do more talking therapies.

● Professional experts we consulted with told us there is a high mortality rate for people with eating disorders. Staff had not received training in end of life care should it become required. People had discussed and recorded their wishes around who to contact should they need to be re-admitted to hospital. However, we saw no evidence of any other discussions where people had been consulted about their wishes at the end of their life or in relation for treatment in the event of a serious illness.

● Some people do not always wish to discuss this topic. In these cases, this should still be recorded and approached again at a later date once the person has had more time to reflect on their wishes. If people's end of life wishes are not recorded, it can mean their rights and preferences are not upheld in the event of serious illness.

The provider had failed to ensure that people's preferences had been fully explored and recorded in relation to goals, needs and end of life wishes. This was a breach of regulation 9(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have

to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People using the service were able to communicate verbally and understood information being shared with them. They were able to speak up and told us they felt comfortable approaching staff.
● Some people used other tools to communicate as they struggled to speak verbally if they were anxious or upset. In these circumstances staff supported them to use cue cards and pictorial forms of communication.
● Staff also understood that people sometimes wished to communicate by sitting silently with them. Staff also supported people to utilise the art or drama therapy sessions to express themselves creatively when speaking was too difficult or traumatic.

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 encouraged to maintain relationships where they chose this. Relatives were encouraged to be a part of people's lives.
● People living at Talbot House were not yet ready to fully participate in community life and most social events. This was slowly encouraged as people became stronger and more confident in their ability to cope with these situations.
● People did go for walks at various points in the week and trips to local shops and cafes.

Improving care quality in response to complaints or concerns
● The provider had a complaints system in place. Complaints were logged in a book and action taken and outcomes were recorded. People and relatives were all aware of the complaints policy and felt there was good communication with the management and staff team.
● Following all complaints, the staff apologised to the person and explained new measures in place to prevent a reoccurrence.

Requires Improvement

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 for this newly registered service. This key question has been rated requires improvement.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There was little evidence of the registered manager being fully involved and having clear oversight of the service. There were no overarching quality assurance systems in place to enable them to effectively assess and be aware of all concerns in order to identify patterns in the quality and safety of the support provided to people.
● The registered manager attended weekly meetings to review people's care and any other issues handed over to them by senior staff. They did not conduct any audits of their own. Consequently, most of the concerns found at this inspection in relation to staffing, risk management, medicines and quality assurance had not been identified and there was no action plan in place for improving standards of care, staff support and record keeping.
● Staff roles were not defined to ensure safe management of the service in the registered managers absence. The registered manager currently spread their time between Talbot House and their two other services. Each time we visited Talbot House, the registered manager was not present on arrival and we were told they were not due in the service that day. Senior staff did not want to take responsibility for the day to day running of the service in the registered managers absence. Staff were unclear on who should be responsible. On the first inspection the registered manager did come to meet the inspector at the service once informed of the inspection.
● The registered manager failed to be transparent in their service specification, despite previous conversations about this with the CQC. The service specification stated that the service provided 24-hour care by a team of nurses and nursing counselling. While the service did employ one registered mental health nurse, they were not employed in the role of nursing and did not carry out nursing specific tasks (although they did use their training and experience when using counselling skills).
● Staff supported people to access health professionals people required via the local community teams.
● Staff did not all understand the risks related to eating disorders or autism. Some staff did not wish to be responsible for medicines and did not see medicines or supporting people with autism as a part of their role. Despite the service supporting two people with autism, staff were not aware of CQC's statutory guidance on Right support, right care, right culture.

The provider had failed to ensure there were systems in place to help them identify concerns found during this inspection. This included concerns about safe and proper care and wellbeing of people, staff skills,

understanding and staff support and poor and inconsistent record keeping. This placed people at risk of harm. This was a breach of regulation 17(1) 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

● The staff did promote person focused care and people's plan of care was agreed via the multi-disciplinary team of professionals and was tailored to individual needs. Despite not all care being person centred and staff not understanding the needs of people with autism, people were happy with the support provided and the service produced positive care outcomes.

● People were involved in all aspects of their care and felt supported and able to speak up.

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; Continuous learning and improving care

● The registered manager and staff team understood the need to be open with people when things went wrong. We saw evidence of investigating incidents and identifying lessons to be learnt. People were then spoken with as well as being sent a letter apologising for the mistake and identifying what the staff would do to try and prevent it happening again.

● Some staff told us they did reflect about incidents but felt this was not always conducted in a way that focussed on learning instead of blame and could be improved.

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

● People told us they felt very involved and consulted about their care. They were supported to complete quality of life questionnaires for reflection. However, these were more focused on learning about people's feelings about themselves rather than seeking their views about the care provided to them.

● Staff did not all feel supported or listened to by the clinical lead, or that the registered manager was approachable. Not all staff felt able to speak up. The service had not conducted a staff meeting since opening. Staff told us they had repeatedly asked for a staff meeting so they could raise concerns but was told it will be arranged and it never had been.

Working in partnership with others

● The clinical lead held weekly meetings with the GP and regularly consulted people's community consultant psychiatrist if there were changes required to their care. These consultations were detailed and took a holistic approach to care.

● Professionals we spoke with who work with the service gave positive feedback about the way the staff consulted with them and shared information about people's needs and progression. One professional said, "[Staff provide a] very prompt response to all queries and instructions."

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 provider had failed to ensure that people's preferences had been fully explored and recorded in relation to goals, needs and end of life wishes.

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 fully assessed and clear guidance for staff had not been implemented. Medicines were not being safely managed or administered to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were systems in place to help them identify concerns found during this inspection in relation to safe and proper care and wellbeing of people, staff skill, understanding and support and poor and inconsistent record keeping.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide sufficient training and support to enable staff to carry out their duties as well as failing to ensure there were sufficient numbers of suitability trained,

skilled and experienced staff on shift to meet people's needs