Salutem LD BidCo IV Limited

Ambito Community Services South West

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

About the service
Ambito Community Services South West is a domiciliary care agency with a supported living setting which provides personal care for autistic people and people with learning disabilities. The service provides support to people with a learning disability and autistic people, some of whom may also have a physical disability. There was an office in Plymouth for the domiciliary care agency and an office at the supported living location near Liskeard.

The provider had taken over responsibility for the setting in September 2021.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

At the time of our inspection there were 9 people using the service receiving support with personal care. 8 of these people lived at the supported living setting.

People's experience of using this service and what we found

Right Support
The model of care and setting did not maximise people's choice, control and independence. Support did not always focus on people's strengths and promote what they could do.

The service did not have a clear record of any authorisations to deprive people of their liberty. This might have meant they were depriving people unlawfully.

Relatives and professionals told us they did not think people had fulfilling and meaningful, interactive everyday lives. People's records did not clearly describe their aspirations and goals.

There was a lack of guidance on what support people needed to increase their skills and have control over their own lives. People were supported by staff who had not all received the right training to understand and meet people's needs.

People who experienced periods of distress did not always have proactive plans in place which ensured staff

understood the best way to support them at these times. Records did not evidence staff had all received training in supporting people at these times, or on how to restrain someone in the safest way.

The setting was designed as a holiday complex and not for permanent dwelling. Necessary alterations to meet people's needs detracted from the feeling that the individual bungalows were people's homes.

People had limited access to the local community. They lived in a remote location which meant they were reliant on staff who could drive, to take them to the local town.

Staff supported people with their medicines in a way that met their preferences. However, some medicines practices, such as how medicines were stored and administered, were not person centred.

Right care
The service was short staffed and was reliant on agency staff. Some of these worked long hours with little time off but the provider had not identified that this could compromise the safety and quality of people's care.

Staff had not all received training in communication methods people used, such as Makaton.

People's care plans did not give a comprehensive or holistic view of their support needs and preferences. Records contained limited information about any aims or aspirations people had and did not contain clear pathways to guide staff on how people wanted to achieve these or learn new skills.

Risk assessments were not in place for all risks related to people's support needs.

Professionals raised concerns that it was difficult to contact the service and that staff were not always aware of guidance provided by external professionals.

Support for people with what they ate and drank was not always person centred or safe.

Right culture
The provider had not identified that the model and setting of the service limited people's quality of life and did not reflect best practice. The service was not similar to dwellings other people would live in and was distinguishable from surrounding accommodation.

There had been inconsistent management at the service and relatives raised concerns that the service had not improved sufficiently since the provider took responsibility for it.

Staff had not all received training in learning disabilities or person-centred care. This meant they had a limited understanding of best practice models of care.

Relatives told us they did not always feel involved in their family member's life. Records showed they had not always been included when decisions had been made on behalf of people who lacked the capacity to make the decisions themselves.

The provider had not ensured that people's records and staff skills were in place and up to date. This had a negative impact on people's quality of life.

Tools and audits to monitor the service had not been used effectively to ensure the service improved and

met people's needs.

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

Rating at last inspection
The last rating for this service was good (published 30 April 2019). At that time, the setting we visited for this inspection was not part of the service.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ambito Community Services South West on our website at www.cqc.org.uk

Enforcement and Recommendations
We have identified breaches in relation to consent, safe care and treatment, person centred care, governance of the service and staffing at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We proposed to require the provider to report to us each month about the improvements they were making

but the provider closed the service before this came into effect.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Ambito Community Services South West

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by 2 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It also provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager had started working at the service 6 weeks before the start date of the inspection.

Notice of inspection
We gave a short period notice of the inspection so staff had time to support people to understand and consent to a home visit from an inspector.

Inspection activity started on 28 November 2022 and ended on 9 December 2022. We visited the location on 2 December 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used information gathered as part of monitoring activity that took place on 21 June 2022 to help plan the inspection and inform our judgements. We sought feedback from the local authority and professionals who work with the service. 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 3 people and met 2 other people. We spoke with 4 agency staff and 5 permanent staff including the manager and area manager. We reviewed 2 people's records and a variety of records relating to the management of the service, such as audits and meeting minutes. We spoke with 4 relatives by phone. We received feedback from 2 health and social care professionals and spoke to 2 by phone.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed to 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.

Systems and processes to safeguard people from the risk of abuse

- Sometimes people became upset, anxious or emotional. A professional raised concerns that staff did not have the right skills and told us some actions staff had taken had negatively impacted on one person's wellbeing. Incident records showed some actions taken by staff had increased people's anxiety.
- A staff member who specialised in understanding and supporting people's behaviour had been working with the service. The manager told us staff had also received training to support people at these times; however, the records provided did not show all staff had received this training.
- One person who often became anxious, used self-injurious actions to communicate their frustration. There was no plan in place to guide staff on how to reduce the risks associated with these actions or how to support the person's needs whilst they engaged in these behaviours.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Meetings were held with external professionals about people's care and support. There was evidence that advice had also been sought. However, professionals raised concerns that they had not always been made aware of significant information such as accidents, incidents and safeguarding concerns.
- Changes had been made to people's environment and equipment to help reduce anxiety.
- Staff were up to date with their safeguarding training.
- Following the inspection, the provider told us 77% of permanent staff had now completed positive behaviour support training.

Assessing risk, safety monitoring and management

- One person had problems swallowing which meant they were at risk of choking but staff had not received training about this. This meant there was a risk they may not support the person correctly with eating and drinking.
- Some risk assessments were in place but there were not risk assessments on all risks to people. This meant there was a lack of guidance for staff about how to help reduce the risks.

This contributed to the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following the inspection, the provider told us most permanent staff had now completed dysphagia

training and that staff provided by a staffing agency had also completed training in dysphagia.

● Fire safety procedures and equipment had recently been reviewed in each person's bungalow and improvements had been identified to increase fire safety. Actions were planned to resolve these issues but had not yet been completed.
● There were arrangements in place to keep people safe in an emergency.
● People were being supported more frequently to take positive risks but these were limited due to the lack of a clear plan and staff knowledge.
● When staff supported people with their money or financial transactions, these were recorded to help ensure it was being done safely.

Staffing and recruitment
● The service was understaffed. Agency staff were being used to fill any gaps in the rota. The manager told us they used the same agency staff which helped ensure consistent support was provided. The rota showed some agency staff were working excessive hours with insufficient rest. We identified occasions where individual members of agency staff had completed 12 hour shifts on up to 9 consecutive days while also completing multiple sleep in shifts.
● We also identified occasions when an agency staff had completed 'sleep in' shifts at the service during their time off. This did not allow them to have sufficient rest and could compromise the safety and quality of support they provided to people.
● There was no risk assessment in place detailing how many hours or days the provider deemed it safe for staff to work each week, or how many rest days they should have in order to provide safe, good quality care.
● Professionals told us low levels of permanent staff had impacted on people's opportunities to go out and meant people hadn't always received a good quality service.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were in the process of recruiting new staff. They also told us they planned to use individualised adverts, so new staff were specifically recruited to support people on an individual basis. They also intended to involve people in interviews.
● There was a suitable recruitment and induction process which meant staff recruited were suitable to work with vulnerable adults.

Using medicines safely
● When people took 'when required' medicines (PRN), guidance was available to inform staff what these were for and when to offer them. However, staff did not always record whether the medicines had been effective. This meant any changes needed to the type or dose of medicine might have been missed.
● Medicines errors were not always recorded correctly. On one occasion a staff member had dropped someone's medicines but had not recorded all the medicines they had dropped. This meant any further action or learning may have been lost.

This contributed to the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff who administered people's medicines had been trained and assessed as competent to do so. However, not all staff had been trained. This meant that 2 trained staff went to each bungalow at set times to administer people's medicines. This could impact on the support the people these staff were meant to be

supporting could receive during this time. The manager told us they intended to train all staff so people could be supported with their medicines by whichever staff member was supporting them.
● Following the inspection, the provider told us most permanent staff had now completed medicines training.
● Everyone being supported by the service required support to take their medicines. Records were kept in each person's home of any medicines administered. These were checked regularly by staff and management to ensure people had received the correct medicines each day.
● People's individual support plans described how they preferred to be supported with medicines.

Learning lessons when things go wrong
● Incidents where people had become distressed or anxious were recorded and we were told the provider's behavioural team reviewed them; however insufficient action had been taken as a result to help ensure staff understood how to support people at these times.
● Staff recognised incidents and reported them appropriately.
● Staff told us they were offered the opportunity for debriefs after any incidents.

Preventing and controlling infection
● Staff were aware of the importance of infection control.
● Staff supported people to keep their homes clean.

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

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

- Information about what affected people's quality of life had not always been sought or understood. This meant opportunities to personalise people's support had been missed.
- People had not been supported to develop friendships or social networks. The location of the service meant people had to travel by car in order to interact with the local community. This meant people had become dependent on staff for company.
- The staff team tried to develop routines and plans with people that met their preferences. However, people's records did not provide a comprehensive or holistic picture of their needs and interests. This limited the amount of control people had over their lives.
- People were not engaged in meaningful activities throughout their day. Whilst at home, people had little to do. Relatives and professionals raised concerns that people were not supported to follow their interests. During the inspection, people had little to occupy their time but often sought staff attention.
- People's records did not all contain clear pathways on how to support people to achieve any goals or aspirations and lacked clear guidance on how to help people develop new skills.
- When possible, staff supported people to undertake daily tasks such as cleaning and cooking; however, there was no clear guidance to help ensure the support they received helped them engage in the task, was consistent and helped maintain or develop skills and independence.

This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff were using the information they knew about people to help build relationships and trust with people.

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

- The provider told us most people at the service needed what they ate monitoring by staff. They told us that for some people, this was because there were concerns about people not eating a balanced diet. However, records showed what the meal was and the percentage of the meal the person ate. This meant it was not possible to identify whether the person had eaten the healthier or unhealthy parts of their meal.
- The amount some people drank was recorded online to help ensure they drank the right amount to maintain their health. The system did not add up correctly what people drank. The manager was aware of this, but no staff member was responsible for monitoring the actual total amount of fluid people had consumed.
- Some relatives raised concerns that staff did not always encourage people to eat a healthy and varied diet

to help them to stay at a healthy weight. Staff understood people's dietary needs but had not all completed training in nutrition. Guidance was not available for staff on how to encourage people to eat a healthy diet.

This contributed to the breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People were involved in choosing their food, shopping, and planning their meals.
- Following the inspection, the provider told us most staff had now completed nutrition training.

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

- The manager was unable to confirm which people had authorisations for the service to deprive them of their liberty and the information was not easily available. This meant staff might have deprived people of their liberty unlawfully, and if there were any conditions attached to any authorised restrictions, these might not have been adhered to.
- The lack of oversight of authorisations meant the staff and manager were unable to monitor restrictions to ensure any changes or increases were escalated to the relevant authority. Staff monitored one person from outside, when they weren't providing direct care or support to the person. Due to the lack of information available, it wasn't clear that this continuous supervision had been authorised.
- Assessments of people's capacity to make certain decisions had not been completed.
- When decisions had been made for people, these had not always been made in conjunction with others who knew them well, to help ensure they were in the person's best interests.
- One person had certain food items stored in a bungalow used by staff. It was not clear the person had consented to this.

This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following our site visit, the manager told us the person's consent to this was sought and recorded.
- Following the inspection, the provider told us assessments of capacity were being completed for the people living at the service.

Staff support: induction, training, skills and experience

- Staff did not have the skills needed to meet people's identified needs. Almost half the staff team had not had training in learning disabilities and not all staff had completed training in person centred care. Some people used Makaton to communicate but staff had not completed this training and were thus unable to

support people's preferred communication style.
● For some people, it was important to be supported by staff they knew well and trusted. This was not always possible and had a negative impact on how people spent their day. For example, one person would not interact with staff they did not know well. If supported by staff they did not know well, they would spend most of their day alone, with little interaction.
● Professionals also reported that the lack of consistent staffing had impacted on people's wellbeing as guidance to meet their needs had not been consistently followed.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The manager had identified that staff training needed improving and had discussed this in a staff meeting. Following the inspection, the provider confirmed most staff had now completed learning disability training and training in person centred care.
● The manager was aware of the issues caused by lack of staff consistency and told us core teams would be developed for each person. This would enable staff to get to know people well.
● Staff were keen to understand people and the way they viewed things, to help tailor the support they provided. Professionals fed back that staff interacted well with people. One staff member explained, "It's important to know […]'s back story so we can understand them."
● The provider used an online system which enabled them to share best practice and any changes to guidance with staff; it also allowed the manager to share local information with them. Staff told us they found the system useful.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked with health and social care professionals to understand and meet people's needs. However, all professionals raised concerns about difficulties in contacting the service and staff.
● A professional told us assessments provided to help staff meet people's needs were not always followed. They told us for one person this had had a significant impact on their quality of life.
● There was some information in people's care plans about their oral health needs but not all staff had completed oral health training. Following the inspection the provider confirmed nearly all staff had now completed oral health training.
● The staff and manager worked with the owner of the properties, to advocate on people's behalf regarding repairs and replacements.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed 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

- The service was not operating in line with the principles of Right support, right care, right culture. The provider had failed to recognise when taking over the site that the design of the service would mean people's choice, control and independence would not be maximised. They had also failed to recognise that it did not fit the principles of supported living.
- The remote location meant people were unable to easily integrate into their local community and as a result they led isolated lives. The service was geographically distant from any community facilities. There was no opportunity to walk or use public transport to get to the local town which was 2.5 miles away. Regardless of their level of independence, people would always be reliant on having staff who were able to drive. This reduced opportunities for people to form and maintain everyday relationships with others and develop social networks.
- People were not living in an ordinary setting similar to that of any other person. The service was in a remote location accessed by a private lane off a busy main road and was distinguishable from surrounding accommodation. The service was clearly separated from surrounding houses and was comparable to a campus style service. The accommodation on the site was all for people with a learning disability. One of the bungalows was being used as a staff room and a house on the same site was used as an office for management.
- The service's improvement plan stated, 'Notices displayed to ensure visitors report to the office on arrival. Visitors procedure displayed in staff's area.' These notices made it clear that this was a care setting and set it apart from dwellings of any other person.
- The properties people lived in had not been designed as long-term dwellings but had been built as holiday accommodation. One person raised concerns that the neighbouring farm kept them awake at night. This was because the bungalows had not been designed to block out noise.
- Some adaptations had been made to the bungalows, but these sometimes detracted from a normal environment. For example, one person did not always like staff to be in proximity. As their bungalow was small, a shelter had been built directly outside their front door so staff could remain close by when the person wanted time alone. This meant the person's view from their bungalow was of the hut where staff were observing them.
- Due to the proximity of the bungalows to each other and the lack of sound proofing present in each bungalow, high fences had been put round some bungalows to reduce the impact people had on each other. These were unsightly and further segregated people from others.
- Individual's bungalows were not always treated as their own properties. A senior manager had requested

a medicines cabinet be put in one person's bungalow to store their medicines. The person had not been consulted and there was no record to show they needed one. This was not treating people as individuals who had autonomy over their own homes.
● The remote location of the service and the distance of the bungalows from the main house meant communicating externally was difficult. Relatives and professionals reported that, contacting people or staff using the landline, mobile phone or using wifi had all proved difficult. In addition, an incident form showed that a staff member had identified a medicines error but had been unable to contact external professionals as the call kept failing.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● There had been a lack of consistent leadership at the service. All relatives we spoke to had concerns about the service and the fact sufficient improvements had not been made since the provider took responsibility for the service. Comments included, "They are improving and are assuring us but it's still not yet where it should be" and "They took over a failed service, but it's been over a year now."
● Professionals raised concerns about a lack of leadership at the service which had resulted in staff not meeting people's needs.
● Checks of various aspects of the service's performance had been completed and monitored. Outcomes of these had been used to develop an action plan for the service. However, these processes had failed to achieve compliance with the requirements of the regulations as detailed in this report.
● There was no monitoring system in place to check the service was working in accordance with the underpinning principles of supported living or Right support, right care, right culture.
● Previous checks of staff at night had raised concerns as they had found staff asleep who were meant to be awake; but no checks had been completed since, to ensure improvements had been made.
● The manager had been in post for 6 weeks and had focused on getting to know the service and making the immediate changes that were necessary. They were aware of the provider's system of audits but had not had opportunity to complete them. This meant key information and improvements may have been overlooked.

This contributed to the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff were positive about the manager and told us they acted on any concerns staff raised. Comments included, "[…] is there if you need them. They listen and are very responsive if you have a problem. It's about what can we do right now. We come up with something together. We feel appreciated."
● The manager told us they had received good support from the provider when they started working at the service. They told us this helped them feel able to make the required changes to the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives gave feedback that communication with their family member, managers and staff was not always effective and that they did not feel like a valued part of their family member's life. Comments included, "I've no idea who helps […] as there are no meetings, nothing" and "I think they don't get that family is very important." In addition to the remote location of the setting, this isolated people even further.
● Relatives told us they had not always been included in decisions about their family member.

● People had not been asked whether they were happy receiving support from the organisation or whether they would prefer a different provider. This was not in line with the principles of the supported living model of care.
This contributed to the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The new manager told us they understood the importance of building relationships with people's relatives, to help staff understand people's needs and preferences.
● The manager had identified that they needed to tailor processes to each individual in order to collect people's views of the service. They told us they intended to do this in the future.
● Staff were keen to create an inclusive culture. It was not safe for one person to have a Christmas tree in their bungalow, so staff had helped them paint one on their wall.
● The manager told us they encouraged staff to have a voice and share their opinions and ideas.

Working in partnership with others
● The manager told us they and the staff had worked with a wide range of professionals to understand people's support needs. However, a professional told us communication with the service was difficult which meant they were unable to monitor and review people as needed.

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 manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people were consistently protected from the risk of harm.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The setting and service did not enable people to live full, meaningful lives every day.

The enforcement action we took:

Imposed positive conditions

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured any authorisations to deprive people of their liberty were lawful and understood by staff.

The enforcement action we took:

Imposed positive conditions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured all aspects of the service were reviewed and improved in order to deliver a good quality service in line with best practice.

The enforcement action we took:

Imposed positive conditions

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were enough, suitably qualified and experienced staff available to deliver people's care.

The enforcement action we took:

Imposed positive conditions