Country Court Care Homes 2 Limited

Somerset House Nursing Home

Inspection report

1 Church Lane
Wheldrake
York
North Yorkshire
YO19 6AW

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11 December 2018

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 10 and 11 December 2018. Both days were unannounced.

Somerset House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide nursing, personal care and accommodation for up to 44 older people, including those living with dementia. At the time of our inspection there were 40 people living at the home.

This was the first inspection of the service since the current provider took over in July 2018. We have found multiple breaches in regulation and the overall rating for the service is 'Inadequate'. The service is therefore in 'special measures'.

The inspection was partly prompted by an incident which had a serious impact on a person using the service. This indicated potential concerns about the management of risk in the service and the level of care provided to people. We did not look at the circumstances of the specific incident, as this may be subject to criminal investigation, but we looked at associated risks.

The service is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection a manager was in place but had yet to register with CQC.

The service was chaotic and was not well-led. People's care needs were not being met due to insufficient staffing numbers and unsupported staff. The service was heavily reliant on agency staff and the management team failed to provide any support or leadership to staff members who did not know the people or the service.

Recruitment processes in place were not safe and medicines procedures were not robust.

The management team had completed checks on the quality of care provided. However, a number of these checks had not picked up on the shortfalls identified during the inspection. We found that the management checks focused on paperwork and failed to recognise the lack of care being provided to people.

Staff were not sufficiently trained or supported to enable them to fully understand their role. Staff had not received sufficient training in specialist areas such as behaviours that can be challenging to others, moving and handling and restraint. This meant that staff were not skilled in ensuring that care was provided in a safe and least restrictive way.

People's nutrition and hydration needs were not being catered for. People did not receive the support they required to eat and drink and their intake was not being monitored effectively. Actions were not taken when people required additional support or a referral to a health care practitioner.

Staff did not have knowledge of people which impacted on their ability to provide person-centred care. Staff were very task focused throughout the inspection which led to people's care needs being neglected.

Care plans failed to reflect people's current needs and risks. Poor behaviour management plans placed staff and people at risk within the service. Accidents and incidents were not recorded, reviewed or monitored for trends and reoccurrences. Lessons which could be learned from any incidents were not considered.

The meeting of people's wider needs could be improved through the provision of more meaningful activities that are monitored and reviewed. We received mixed feedback from people regarding the provision of activities.

Care records demonstrated that the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) had been applied. The manager was in the process of submitting all DoLS requests to the local authority as the current provider had been unable to locate copies of applications made under the previous provider.

Relatives we spoke with were not satisfied with the care that was being provided to their loved ones and felt the service was not well-led.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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

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.

There were insufficient staff to meet people's needs.

Recruitment processes in place were not safe.

Medicines processes were not robust.

Risk had not been managed effectively, which had placed people who used the service at risk of harm and injury.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not up to date and staff lacked essential knowledge to enable them to support people safely. Staff were not appropriately supported in their role through regular supervision and appraisals.

People's nutrition and hydration needs were not being met which placed people at increased risk.

Improvements were needed to the premises and equipment to ensure people lived within an environment that met their needs and they had access to working equipment.

People who lacked capacity had their rights upheld under the Mental Capacity Act. We were unable to check whether people had a valid DoLS in place.

Is the service caring?

Inadequate

The service was not caring.

Staff did not treat people with respect or preserve their dignity.

Communication with people during the delivery of care needed to be improved.

People and their relatives felt they did not know the staff and

that staff did not know them.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans lacked sufficient detail to promote person-centred care.

The service failed to provide consistent meaningful activities to meet the wider needs of people.

There was a complaints policy and procedure in place, but the service failed to adequately respond to all complaints received.

Is the service well-led?

Inadequate

The service was not well-led

An effective quality assurance system was not in place. This had led to breaches of multiple regulations. Audits conducted had not been robust and action plans failed to promote continuous improvements to the service.

People, their relatives and staff were not provided with regular opportunities to be involved in decisions about the service or offer feedback. When feedback was obtained the manager failed to act to address concerns raised.

People, relatives and staff told us they had no confidence in the way the service was being managed.

Somerset House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection that took place on 10 and 11 December 2018. Both days were unannounced. The inspection team consisted of two inspectors, two specialist advisors and an Expert by Experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was an evening visit and was conducted by two inspectors and an inspection manager.

Before the inspection we reviewed the information we held about the service. We used information the provider sent us in the Provider Information Return. 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 reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to tell us about within required timescales.

We sought feedback from the local authority commissioning and safeguarding teams.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at meal times. We spoke with nine people who used the service, six relatives, six care staff, the deputy manager and the manager. We spoke with one visiting professional.

We used our Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included a full review of five people's care records. We also looked at specific documents in other people's care records. We viewed the records for four staff relating to their recruitment, supervision and appraisal. We viewed records relating to the management of the service, including audit checks and the provider's policies and procedures. We completed a tour of the building to look at the environment.

Inadequate

Is the service safe?

Our findings

We identified insufficient staff on duty which placed people at risk of serious harm. When we arrived at the home on the evening for our second day of inspection, there was one staff member less than stated on the rota. When we spoke with the care staff, handover had not taken place and they did not know who was on shift that evening. They told us they did not have access to the rotas and were never sure who was working on shift.

We observed call bells ringing continuously. On two occasions call bells were ringing for over 30 minutes and those people were waiting for assistance. We observed people who were distressed in communal lounges and left unsupervised by staff. Care staff told us they were unable to meet people's basic care needs due to the current staffing levels.

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

We observed people being moved and handled incorrectly, with 'drag' lifts being used. The 'drag' lift is any method of handling where the staff member places a hand or arm under the person's armpit. We observed one person being moved using a stand aid despite their feet remaining on the foot plates of their wheelchair rather than the stand aid. We observed care staff moving another person into a wheelchair. When moving the person, we heard staff say, "This is the wheelchair I reported yesterday, it is not safe." Despite this being fed back to the provider on day one of the inspection, this practice was still occurring on our second visit.

There was inadequate provision of pressure relieving equipment, which placed people at increased risk of skin damage and pressure sores developing. We observed one person sat on a pressure cushion which was turned off. Other people were sat on faulty pressure cushions. Pressure mattress settings were all on a high setting regardless of people's individual needs. People at risk of developing pressure sores were not being repositioned as described within their care plan. One person was identified in their waterlow risk assessment as being at high risk of pressure sores, however staff told us, and records confirmed, that the person was not repositioned through the night, as described in their care plan.

We identified ineffective risk management plans in place to reduce the risk of behaviours that may challenge the service. The manager told the inspection team on the first day of inspection that no-one who used service presented challenging behaviours. A review of records and discussions with staff confirmed that there were at least three people who could be physically aggressive. Records for these people's behaviours were inadequate to provide staff with guidance they needed. Care staff told us how one person required up to four care staff at times to provide personal care. This was because two care staff would hold their hands whilst the remaining staff saw to their personal care needs. This was a form of restraint, and we found no evidence of authorisation for this restraint, under a best interest's decision-making process. Staff confirmed they had not received training in using physical restraints.

One person was identified as having diabetes. However, there was no risk assessments or information within

their file about this medical condition. Another person had fluctuating skin integrity in one area, however the care plan and risk assessments failed to identify this area clearly. There were no body maps in place and no up to date recording of their current skin integrity. One person was identified as being at risk of dehydration. The manager had implemented a risk assessment tool but this failed to record any scores which would allow the staff to identify the risk. The MUST tool (malnutrition universal screening tool) was not completed for this person which meant there was no effective risk assessments in place to manage the risk of dehydration or malnutrition.

Details within people's risk assessments and care plans for catheter care lacked detail of the actions for staff to follow to reduce the level of risk.

Where serious incidents, including falls, had taken place we found insufficient evidence of monitoring or remedial action. We identified one person who had fallen and inadequate observations had been completed after the fall to ensure their safety. We identified through daily records that another person had suffered a fall and this had not been logged on the relevant incident paperwork or followed up.

When people presented with concerns that needed referring to health care professionals, contact was delayed or did not take place. One person was identified in their daily notes as showing signs of ill health. Despite this person receiving regular visits from their GP, this information was not shared.

Infection control concerns were observed during both days of inspection. We observed that when people were supported to go to bed their chairs and cushions were wet (due to incontinence) and dirty. We did not observe any staff attempting to clean these chairs. Some people's bedrooms were not tidy and contained many dirty pots and cups from throughout the day.

Medicines management was unsafe. We identified that the fridge in place for the storage of medicines had consistently been recorded as significantly above the required temperature. All medicines within the fridge had been compromised and needed to be disposed of. The manager had failed to identify or rectify this concern prior to our inspection. We also identified medicines that should be discarded 28 days after being opened, still in use after this date.

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

We identified equipment that was not maintained. A faulty wheelchair was being used to support people moving. Staff told us this has been reported as faulty the previous week and a relative told us this wheelchair caused an accident for a person recently. We found people were using pressure cushions that were broken or not inflating correctly.

This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for four care staff. Three of the checks had been completed under the new provider. All three of these care staff had started work without a Disclosure and Barring Service (DBS) check or references in place. The DBS carry out a criminal record and barring check to help employers make safer recruiting decisions. Recruitment paperwork was not robust and was unsafe.

This was a breach of Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse and improper treatment. We observed people to be neglected during our inspection. On both days of inspection, we identified people with dirty nails who smelt and looked neglected. Records showed that a significant number of people had not had a bath or any alternative personal care, in month. We identified instances where the manager had failed to investigate immediately upon becoming aware of allegations of abuse. Although relevant notifications and safeguarding referrals were submitted, these lacked the full detail of the concerns raised by family members. The local authority had also communicated that the manager failed to fully investigate concerns identified in relation to another person, choosing only to respond to certain elements of the concerns raised.

The manager failed to follow systems and processes to prevent the abuse of people.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We sampled maintenance records which showed safety checks and servicing had been completed on the gas supply system, hoists and slings, fire servicing equipment and the electrical installation.

Inadequate

Is the service effective?

Our findings

The environment did not support the needs of people living with dementia. There was very little signage and colour contrast was not used as a means of supporting people to find their way around the building. We observed many people confused about where to go. The corridors all looked very similar and the doors, apart from different names, were the same. There were small name plates on the doors but nothing else to help identify a person's room.

This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were inadequately trained to meet people's needs. The provider's training matrix showed that one member of staff had been in post for four weeks but had not completed any training. No staff had completed challenging behaviour training despite people presenting with this need. The matrix recorded that one member of staff had completed moving and handling training recently. However, this member of staff confirmed during the inspection that this did not include the practical element of the training. We observed this staff member and all other staff members, using incorrect moving and handling techniques, including 'drag lifting', throughout the inspection.

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

People did not receive the support they required to meet their nutritional and hydration needs. We observed the dining room experience during the first day of inspection to be chaotic. People who required support to eat were not receiving this. We saw people whose care plan stated they ate better with finger food, being provided with mashed potato and gravy. No one was offered the opportunity to wash their hands before or after the meal.

On the first day of inspection we found one person who hadn't been offered breakfast at 10:30am. We found a second person who was still in bed at 11:22am. We checked their daily records and nothing was recorded for this person since 5:30 am. They had not had anything to eat or drink that day and had no access to fluids. This person's relative confirmed that on three occasions the week previously they had needed to get this person up as they were still in bed at 11am. They also confirmed that as a regular visitor to the service they had seen people regularly going without food and fluids.

The service was ineffective at monitoring people's hydration and nutritional intake and acting on concerns. Records failed to accurately reflect what people ate or drank. We observed one person not eating anything for lunch during our first day on inspection. On the second day we checked their food chart which stated they had eaten a full portion. Where fluid intake was being monitored and totalled there was no target for people to reach. Staff were unaware of what the totals meant and when they would need to take action. These charts were ineffective as a tool to monitor and support people's fluid intake.

One person had been advised by a dietician to have their weight recorded weekly. However, this was not taking place.

Another person had continuously lost weight since July 2018. However, no action had been taken to increase the frequency with which they weighed the person, to effectively monitor this change. The care plan did not advise fortified meals for this person until 27 November 2018, despite clear weight loss since July 2018.

This was a breach of Regulation 14 (Nutrition and Hydration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans identified people's capacity to make decisions under the Mental Capacity Act (MCA) 2005. 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Since taking over the service, the provider had identified that the monitoring of DoLS applications was not robust and they were not satisfied that everyone who required a DoLS had a valid one in place. The manager had started submitting new DoLS applications to the local authority in 'stages' as requested by the local authority. Whilst we found some best interest decisions in place, not all areas of care were consented to including the use of restraint.

Inadequate

Is the service caring?

Our findings

We found that people's dignity was not promoted or respected.

During the inspection we observed people were not supported with their basic needs in a timely way. People were not supported to the toilet all day. A number of people were observed to have been incontinent and smelt. This was fed back to the management team at the end of the first day of inspection. On return to the service for the second day we found the same lack of care had been provided to people. One person had been incontinent and not been changed throughout the whole day. We asked a member of staff to change this person but they were not available for a further 40 minutes. The person and their visiting relatives were extremely distressed about the poor level of care provided. We observed one person eating their full meal with their fingers, despite their finger nails being covered in faeces.

We identified that one person had recently gone to bed in their day clothes because no nightwear was available. The manager told us this was because the washing machine had broken. Failing to ensure adequate night clothes were available for people demonstrated a lack of respect.

Staff failed to communicate effectively to people to ensure they understood the care being provided. We observed members of staff had limited interaction with people especially during the delivery of care. This included when supporting with meals or during moving and handling.

We completed a SOFI observation in one of the communal lounges for 30 minutes on the first day of inspection. Throughout this period there was no presence or interaction with the three people within the lounge from any staff.

This was a breach of Regulation 10 (privacy and dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service didn't feel that their needs were met by staff. Comments included, "Some staff say they will look into things for you but you never see them again" and "Getting a bath is a bit hit and miss."

People's friends and relatives were welcome to visit; there were no restrictions to the amount of time they could spend at the service. Relatives we spoke with shared concerns about the level of care people received. Comments included, "All the experienced staff have left, none of them know [name of person] now" and "We visited one day and [name of person]'s hair was very dirty. We had asked for it to be washed once a week. The chart said it had been washed the day before; this was wrong."

People's cultural and religious needs were not considered when care plans were being developed. Information about people's religious beliefs was not included within the care plan.

People's records were not stored securely and access was available to all who entered the service. We shared this concern at the end of the first day of the inspection, however, we found the same open access to

confidential information on the second day.

There was no information regarding advocacy services in the building, to inform people how they could access independent support to express their views and wishes.

Inadequate

Is the service responsive?

Our findings

The provider had a complaints policy and procedure in place. We looked at the complaints log but this did not reflect the complaints received. We identified responses to complaints that were not on the log and details of the complaint made were not available. Complaints did not always evidence lessons learnt or how actions could be taken to prevent reoccurrence.

Throughout the inspection relatives told us about many complaints and concerns that had been raised with the management team which were not reflected in the complaints log. Comments included; "The deputy manager is not always available. I have asked to see them four or five times before I get a visit" and "I think there are problems with [name of person] not having a bath, but I don't know how many times the management have been asked, still nothing gets done."

This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service failed to provide person-centred care. We found that care plans were not always person centred as they did not reflect people's individual preferences around their care. Care records did not identify anything about people's history, past employment, hobbies or past times. We observed numerous occasions where staff on shift did not know the specific care needs of people. For example, one person requested a drink and the staff member had to ask a colleague what type of cup to use. We observed this person being provided with three types of cups throughout the inspection. None of which the person drank from. We checked this person's care plan which failed to record what type of cup this person could drink independently from.

Where specific details were recorded in people's care plans, this was not adhered to. For example, two people's care plans stated that they liked baths twice a week, yet their care records confirmed they had not received a bath in one month. Another person's care plan recorded that they required support and prompting with meals, however, we observed this did not happen.

There was a high use of agency staff. These staff told us they did not know what was in people's care plans and just knew what to do through asking the permanent staff member on shift. No time was allocated to new staff to read through care plans.

Care plans contained basic information and although reviews were recorded there was minimal evidence of care plans being updated or developed when people's needs changed, for example when a catheter was no longer in place. The plans included information about people's individual needs, such as; incontinence, skin integrity, moving and handling, personal care and nutrition. However, they lacked specific instructions for staff to follow. We found staff recording in daily notes to be repetitive and failed to accurately reflect how care was provided in line with the person's care plan.

This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

We received mixed feedback about the provision of activities to meet people's wider needs. People told us, "The activities are very poor. I stay in my room most of the time", "The activities worker sees me every day; they know what I like to do" and "Occasionally the staff will sit and have chat with me but they are usually busy." There was an activities worker in post but they were on leave during our inspection. In their absence, no activities were planned for people.

An activities notice board was on display in the entrance to the service. This board detailed daily activities including visiting animals, dominoes, manicures and one to one time. However, this board was displaying activities for the week of inspection even though no activities were scheduled. Relatives told us, "People sometimes go out on trips" and "[name of person] is bored. This is not enough to stimulate them."

There was the option within people's care plan to record their end of life preferences. We saw some people had completed this.

Inadequate

Is the service well-led?

Our findings

The service had a manager who had been in post for eight weeks but they had yet to register with CQC.

Throughout the inspection we found the service to be chaotic and shifts were not being formally managed. Staff who did not know the people or the service were left to 'lead' on shifts without any input or support from the management team. Inadequate staffing levels were having a direct impact on the care being delivered to people. We observed that when staff were struggling to meet the needs of people, management staff remained in their office and did not offer support.

We found there was a lack of systems and processes in place to ensure that people received a good standard of care and compliance with legal requirements. The was a clear lack of leadership and oversight of the service which impacted directly on care provided to people. Audits completed on medicines processes and care plans had failed to identify the concerns we found during our inspection.

Despite our concerns being shared at the end of our first day of inspection and an action plan being sent to us, we found that immediate action to address our concerns had not been taken. The action plan told us a number of actions had been immediately completed, however, on the second day of inspection we found they had not been done.

Staff did not feel supported by the management team in place. They told us they had no faith in any of the management team as they had failed to respond to their concerns or feedback. There were records of staff meetings taking place. However, no night staff had attended these meetings. One staff member told us, "Night staff have been frequently asking for night meetings so we can attend and share our views. We have asked the manager four or five times, but we are not listened to."

There had been a lack of supervision and development of the staff team. Gaps in knowledge and skills had impacted on the delivery of safe, person-centred care that met the needs of the people who used the service. A lack of management oversight in this area meant this had remained undetected.

There was a lack of robust record keeping in relation to actions taken following accidents and incidents. This meant monitoring or oversight of accidents and incidents was ineffective. There was no monitoring of trends or recording of any lessons learnt.

Record keeping was poor. Daily notes did not reflect the care people received throughout the day. Records failed to be accurately completed and sometimes portrayed a false picture of care being delivered. A number of records had not been completed for over two weeks.

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

Relatives did not feel this was a well-led service. They told us, "The manager is not much use. They don't

come out of the office" and "Verbally things don't get passed on."

During the inspection the management team did not act in an open and transparent way. Whilst in discussion with the manager and deputy manager about people with high support needs or specific concerns, they failed to inform us of two people's increased support needs and details of recent injuries obtained within the home. The management team advised that there had been no occasions where they had been understaffed during a shift. However, staff, residents and relatives confirmed that on a recent night shift only one staff member was on shift between 7pm and 10pm. The manager advised us there were no people who used the service that had behaviour that challenged the service. This was incorrect.

This was a breach of Regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately following our inspection, we formally notified the provider of our escalating and significant concerns. We asked the provider to tell us what urgent actions they would take with immediate effect to mitigate the risks we identified at this inspection. We received a response with their improvement action plan within the timescale requested. The provider immediately brought in a management team to oversee and lead on improvements required for the service. The local authority and Clinical Commissioning Group commenced daily unannounced visits to monitor and ensure the safety of people who used the service.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. From the records we saw, the provider was not informing us of relevant important events. This will be addressed outside of the inspection process.