Gracefield Health Care Limited (GHC)

Gracefield Health Care Limited (GHC) - 31 St Domingo Grove

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Gracefield Health Care Limited (GHC) - 31 St Domingo Grove is a residential care home providing accommodation for persons who require nursing or personal care to up to 6 people. The home is situated in a residential area of Anfield, Liverpool and provides accommodation across four floors. The service provides support to people with a learning disability, autistic people and people with mental health support needs. At the time of this inspection there were 6 people living at the home.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems at the service did not support this practice.

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

Right support: There was an increased risk that people could be harmed, and restrictive practices did not fully take account of person-centred needs;
Right care: Care and support did not always reflect current evidence-based guidance, standards and best practice to meet the needs of autistic people and people with a learning disability;
Right culture: The culture of the service did not focus on ensuring people received person-centred care. There was a lack of manager oversight and there was no system in place to ensure learning from incidents.

There were ineffective processes in place to protect people from abuse or improper treatment. People were exposed to serious risk of harm as their care needs and associated risks had not been routinely assessed, monitored and mitigated. There was no manager oversight of incidents. Medicines were not managed safely. The home did not always ensure best practice guidance in relation COVID-19 was followed. Recruitment processes were not safe.

Staff did not have the training or support needed to make the human rights-based decisions that would have helped them to provide better, safer care to autistic people and people with a learning disability. There was no involvement of professionals in the development of people's support plans or behaviour support plans. The provider did not always promote good health and wellbeing outcomes for people. People had access to local and community health services. However, people were not always encouraged to engage with these services.

The environment was poorly maintained, and some people's bedrooms were quite bare and contained minimal personal items. People's privacy, dignity and independence were not respected, and people were not always supported to be involved in decisions about their care. Some people's communication care plans contained out of date information. Relatives and people told us action had not been taken to address on-going complaints.

People were supported to maintain relationships with people important to them. However, there was limited evidence that people were encouraged to develop relationships with people in the wider local community People's care needs were not regularly reviewed. People were therefore at risk because staff did not have the up to date information required to meet their needs.

People were at risk of serious harm, because the service was not well-led. The registered manager was out of touch with what was happening in the service. The provider failed to share information with external organisations and professionals. Governance processes were inadequate and did not always keep people safe, protect their human rights and provide good quality care and support.

People and relatives told us that they could visit their loved ones. Records we viewed confirmed this. There were limited activities that took place inside the home. However, we saw that people accessed the community regularly to partake in activities of their choosing. People were supported by a small and consistent staff team. There were enough staff to meet people's needs. We saw some caring interactions from staff. However, most interactions were task orientated.

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 4 September 2019).

Why we inspected
We undertook a targeted inspection to look at the preparedness of the home in relation to infection prevention and control during this period of high levels of coronavirus infections and winter pressures.

We inspected and found there was a concern with the environment and infection control practices, so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of safe, effective, caring, responsive and well-led.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

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

Following the inspection, we took urgent action to ensure people were safe. We also required the provider to submit an urgent action plan to demonstrate how they planned to mitigate the most serious risks identified in this report.

Enforcement
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 safe care and treatment, safeguarding people from abuse, consent, recruitment practices, person centred care, governance and treating people with dignity at this inspection.

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

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

Follow up
We will 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Gracefield Health Care Limited (GHC) - 31 St Domingo Grove

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 included checking the provider was meeting COVID-19 vaccination requirements. 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 completed by two inspectors.

Service and service type
Gracefield Health Care Limited (GHC) - 31 St Domingo Grove 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. Gracefield Health Care Limited (GHC) - 31 St Domingo Grove is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the first day of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people at home to speak with us. The second and third days of the inspection were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 five people who lived at the home and two relatives to understand their experience of the care provided. We spoke with ten members of staff including the registered manager, team leaders and care workers.

We reviewed a range of records. This included four care plans and associated documentation. We looked at three staff files in relation to recruitment and multiple medication records. We reviewed multiple records relating to the management of the service and a variety of policies and procedures.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data and quality assurance records. We shared our concerns with external agencies, such as the fire service, the local authority commissioners and the safeguarding authority.

Inadequate

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 has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- There were ineffective processes in place to protect people from abuse or improper treatment. This exposed people living at the home to a risk of harm.
- Physical restraint was used frequently without due regard to the person's needs and safety. Records showed that physical restraint was used as a first resort and this was not always a proportionate response to protect the person or others from harm.
- A person who lived at the home disclosed to a member of the inspection team they had been physically and verbally abused by a member of staff and despite raising this with the manager, no action was taken. We shared our concerns with safeguarding and ensured the provider took immediate action to protect the person.
- When people had unexplained bruising there was no follow up action taken and there was no evidence staff shared these concerns with safeguarding. This meant people were exposed to further risk of harm because of a lack of action to protect them. One relative told us they had found multiple bruises on their loved one and told us this was from staff interventions which were to support the person during periods of emotional distress. We shared our concerns with safeguarding.

There was a failure to protect people from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- People were exposed to serious risk of harm as their care needs and associated risks had not been routinely assessed, monitored and mitigated.
- Risk assessments were either not completed, not reflective of people's current needs, or detailed enough to guide staff on safely supporting people. For example, a risk assessment was not in place for one person who used self-injurious behaviour to express their feelings. For another person, a falls risk assessment was not in place despite the person experiencing multiple falls, some of which required hospital treatment. This placed people at risk of avoidable harm.
- People were not safe in the event of a fire. We found multiple and significant concerns in relation to fire safety such as defective fire doors, the absence of regular fire drills, an overdue fire risk assessment and personal emergency evacuation plans lacked detail. We shared our concerns with the Fire service.
- Accident and incident processes were inadequate. There was no manager oversight of incidents and analysis was not completed, or action taken to reduce the risk of further incidents. The failure in this process meant the registered manager was unaware that staff were physically restraining people.

The lack of systems to fully understand risk and do all that is reasonably practicable to reduce the likelihood

of harm was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the fire service visited the service and outlined the action needed to reduce the risk of harm to people in a fire situation. The provider gave assurances that they were acting upon the recommendations and were taking steps to update care plans to reflect people's current needs and risks.

Using medicines safely
● Medicines were not managed safely.
● People did not always receive their medicines as prescribed. For example, one person frequently missed a regular dose of prescribed medicine. Records showed this had a negative physical impact on this person, and the nature of this impact compromised this person's dignity.
● Care staff who administered medicines did not have appropriate competency checks to ensure their practice was safe.
● Medicine risk assessment and care planning was insufficient. Staff did not have access to clear information about when to administer as and when needed medicines.
● Medicine administration records (MAR) were not completed in line with best practice guidance. There were gaps in relation to medicine quantities, allergy information and administration. Poor records are a potential cause of preventable medication errors.

Medicines were not administered or managed safely. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were at risk because measures to prevent and control the spread of infection were ineffective.
● The home did not always ensure best practice guidance in relation to COVID-19 was followed. For example, we observed multiple staff not wearing fluid repellent face masks within close contact of people living at the home. Relatives we spoke with confirmed that this was common practice, comments included; "I don't think staff wear them now, not seen them wearing them for a while."
● We observed staff walking through two floors of the home and touching multiple surfaces prior to completing a COVID-19 lateral flow test prior to them starting work. This practice increased the risk of infection spreading to people living at the home.
● The home was not clean and hygienic. Widespread concerns regarding cleanliness were found. For example, carpets, doors and handrails were dirty, one person's mattress was heavily stained, and another person's duvet was soiled.

The failure to manage risks related to the spread of infection is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was facilitating visits for people living in the home in accordance with the current guidance.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Staffing and recruitment

- Recruitment processes were not safe, and people were at risk of being supported by unsuitable staff.
- Recruitment records showed that full employment histories were not always recorded, or corroborated, and appropriate references were not always in place. We asked the registered manager to follow this up immediately.
- When information was missing from application forms, this had not been appropriately followed up.

The provider had failed to ensure recruitment processes were appropriate and safe. 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 supported by a small and consistent staff team. There were enough staff to meet people's needs.

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 there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider was not working within the principles of the MCA. People were at risk of having their liberty unlawfully restricted and inappropriate decisions could be made on a person's behalf if they lacked capacity to make the decision for themselves.
- Restrictive practices, such as the use of physical restraint, were being used without appropriate legal authority. Processes had not been followed to ensure these practices were the least restrictive option and, in the person's best interest.
- The system for ensuring DoLS applications were submitted within the required timeframe were ineffective. This resulted in the provider submitting two DoLS applications late.
- When DoLS were authorised with conditions, the provider did not always adhere to conditions to ensure any restrictions were carried out safely.
- We did not see any evidence of mental capacity assessments in people's care plans.

There was a failure to act within the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff did not have the training or support needed to make the human rights-based decisions that would have helped them to provide better, safer care to autistic people and people with a learning disability. For example, not all staff had received training in positive behaviour support and safe use of restrictive interventions. This demonstrated a failure to follow the principles of Right Support, Right Care, Right Culture and meant people were at risk of being supported by staff who did not have the necessary skills to undertake their role safely.
● There was no collated training record in place to act as an overview of staff skills and training. This meant the provider did not have oversight to ensure staff had received the training required for their roles, and their knowledge was up to date.
● A staff member responsible for fire safety checks told us they had not received any specific training to ensure their competency in this area.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's care needs had not always been completed in detail to include each person's physical and mental health needs. Most care plans lacked detail around people's individual needs. This meant people were at risk of not having their needs safely and effectively met.
● The care and support provided specifically in relation to physical restraint did not reflect current evidence-based practice and standards.
● Care plans were not updated or reviewed in a meaningful way. They did not evidence how people had been involved in them.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider did not always promote good health and wellbeing outcomes for people.
● People had access to local and community health services. However, people were not always encouraged to engage with these services. For example, health professionals told us three people had failed to attend their annual health reviews.
● There was no evidence the provider had worked with health professionals to develop people's support plans or behaviour support plans.

Adapting service, design, decoration to meet people's needs
● The environment was poorly maintained, and some people's bedrooms were quite bare and contained minimal personal items.
● The provider was not following best practice guidance in relation to the design of the home to ensure it met the needs of autistic people and people with a learning disability.
● The registered manager confirmed several areas were due to be decorated and shared their refurbishment plans.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff were aware of people's dietary needs and preferences and we saw people were involved in decisions about what they wanted to eat and drink.
● Staff did not always support people with their dietary needs effectively. For example, one person's care plans outlined dietician advice to restrict calories. Records we viewed did not evidence this advice was being followed as calorie intake was not monitored consistently.
● People were not always supported to maintain a balanced diet. Records showed people chose to consume fast food on a regular basis. However, staff did not always encourage healthier options or educate people about food choices.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People's privacy, dignity and independence were not respected.
- During the inspection, we observed one person on the toilet with the door open with three staff members present. We were allowed to walk past with no warning or consideration of the persons privacy or dignity.
- We observed one person's bedroom and found they had no bed linen, ripped curtains, a smashed window, no toilet seat, damaged walls and clothes were stored on a chair as there was no access to a wardrobe. The person was visibly upset with the state of their living conditions and told us, "I think that all the staff hate me, they're not helping me out with what I need to have for my room."
- Restrictive practices were included in people's care plans. For example, records stated one person could only use their PlayStation if they used the exercise bike for ten minutes. Another person's records stated staff should only provide toilet roll in single sheets. This placed people at risk of degrading care and treatment.
- Staff told us a dummy CCTV camera was installed on the top floor of the home. Staff told people living at the home that the camera worked. This did not protect people's human rights with respect to privacy and dignity.

The failure to ensure people were treated with dignity and respect was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action to improve people's living conditions. By the third day of the inspection, we saw that bed linen had been provided and new curtains had been purchased. The provider reviewed the restrictive aspects of people's care plans and gave assurances staff were no longer carrying out these practices. We have not received any confirmation regarding any changes made to address the concern with the CCTV camera.

- We saw some caring interactions from staff. However, most interactions were task orientated.

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

- People were not always supported to be involved in decisions about their care.
- When people did not have capacity to make decisions, appropriate assessments were not carried out and there was no evidence advocates were involved to support people with decision-making.
- Care records showed a lack of assessment and involvement from people and where appropriate, their relatives.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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;

- Staff did not work in a person-centred way to meet the needs of autistic people and people with a learning disability. They did not follow best practice and the principles of Right support, right care, right culture and were not ensuring that all these principles were carried out.
- People's care needs were not regularly reviewed. People were therefore at risk because staff did not have the most up to date information required to meet their needs.
- The provider did not plan personalised care to meet the needs of all people using the service. For example, when people experienced periods of emotional distress, they did not have effective plans to guide staff.
- Care and support plans relating to community access and activities were in place. However, they did not always include information about how activities were planned or evaluated. It was not always clear whether people had been involved in activities that met their preferences.
- People were supported to maintain relationships with people important to them. However, there was no evidence people were encouraged to develop relationships with people in the wider local community who have shared interests, background and culture.
- There was limited evidence of future planning, or consideration for the longer-term aspirations of each person living at the home. People were at risk of not having their needs and preferences met.

People were not supported with person-centred care, and care did not always meet their needs. This was a breach of Regulation 9 (Person-centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The complaints management process was ineffective.
- Relatives and people told us action had not been taken to address on-going complaints, despite bringing it to the attention of staff and the manager. These complaints related to missing personal items. We found no records relating to the complaints and no evidence they had been investigated and responded to.

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.

● The provider did not always adhere to the Accessible Information standard. There was no policy in place to show the provider's commitment to making information accessible to people.

● Some people's communication care plans contained out of date information. For example, one person's care plan stated staff should communicate using Makaton. However, we were later told that this person does not use this communication system.

● There was lack of information in a format that autistic people and people with a learning disability could understand. For example, easy read or pictorial information.

End of life care and support

● At the time of our inspection, no one using the service required end of life support.

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 there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- People were at risk of serious harm, because the service was not well-led.
- The registered manager was out of touch with what was happening in the service. For example, they were not aware of incidents involving physical restraint. This meant there was no oversight to ensure these practices were the most appropriate intervention or that they were carried out safely.
- Care plans and associated records were inadequate and were not subject to regular review, which meant records were not reflective of people's needs. As a result, people were exposed to the continued risk of harm and poor care.
- The provider demonstrated a poor understanding of the Mental Capacity Act 2005 and its application. This resulted in late DoLS applications and a lack of adherence to authorised DoLS conditions.
- Since our last inspection, multiple incidents had been recorded in the accident book. However, no overarching analysis had been completed to identify themes or trends and action needed to reduce the likelihood of such incidents occurring again in future.
- The provider failed to share information with external organisations and professionals. For example, reportable incidents were not shared with the safeguarding authority and multiple statutory notifications were not submitted to the CQC.
- Our findings from the other key questions showed that governance processes were inadequate and did not always keep people safe, protect their human rights and provide good quality care and support.

The lack of effective monitoring and oversight of the service meant people did not receive effective care and treatment and were at risk of harm. This was a breach of Regulation 17 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; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not promote the provision of high-quality, person-centred care which fully protected people's human rights.
- There was poor collaboration with external stakeholders and other services to ensure people's needs were met and to ensure they received good outcomes.

● The provider had not taken part in any wider social inclusion initiatives to support people to connect with their local communities to avoid people being socially isolated.
● Staff did not have the information and training they needed to provide safe and effective care, and they were not supported to follow best practice for supporting autistic people and people with a learning disability.
● There were no systems in place to obtain feedback from people, their representatives or other stakeholders about the running of the service.

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 People were not supported with person-centred care, and care plans were not regularly reviewed to ensure their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy, dignity and independence were not respected. People were at risk of degrading care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had a poor understanding of the Mental Capacity Act 2005 and its application. People were at risk of having their liberty unlawfully restricted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not safe and people were at risk of being supported by unsuitable staff.