SHC Clemsfold Group Limited

Kingsmead Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 28 and 29 January 2019 and was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been reached. We used the information of concern raised by partner agencies to help plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and January 2019, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and have reported on what we found.

A focussed inspection had been undertaken on 3 December 2018. That inspection was carried out due to an increase in reported concerns and information that suggested people at the service were potentially at risk. The provider was in breach of four regulations of the Health and Social Care Act 2008 (regulated Activities Regulations 2014; Regulation 11 Need for Consent, Regulation 12 Safe Care and Treatment, Regulation 17 Good Governance and Regulation 18 Staffing. Risks to people's safety had not been properly mitigated. There were continued concerns around the management of percutaneous endoscopic gastrostomy (PEG) feeding tubes. There was unsafe and inconsistent use of the national early warning score system to identify and inform staff actions when a person's health deteriorated. Medicine errors continued to be identified and the management of accidents and incidents continued to cause concern. The provider had not always ensured that people's consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. Some people displayed behaviours which may challenge others yet not all staff had received specific training on how to manage such behaviours safely and effectively. Systems and quality assurance processes to monitor and oversee care remained ineffective and were not sufficiently robust to ensure consistent and quality support throughout the service.

Following what was found at the December 2018 inspection, the CQC continued to be alerted of incidents and concerns following that inspection. Due to the nature of the concerns, we determined it necessary to carry out a comprehensive inspection as soon as possible to investigate these concerns, which we did on 28 and 29 January 2019. As a result of these urgent timescales, we were unable to supply the provider with the draft report from the December 2018 inspection as this was still in the process of being completed. However, we provided feedback of the inspection, including the areas of concern that needed to improve, at the end of the inspection. We also provided a feedback sheet detailing those areas. We found that there had been little improvement and that concerns remained over the risks to people's safety. There were continued breaches of the four regulations above as well as a breach of Regulation 9 as personalised care was not consistently provided to all service users.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Kingsmead Lodge provides nursing and personal care for up to 20 people who may have learning disabilities, physical disabilities and sensory impairments. Most people had complex mobility and communication needs. At the time of our inspection there were 10 people living at Kingsmead Lodge. People living at the service had their own bedroom and en-suite bathroom. The service had two areas 'west' and 'east' wing, but operated as one home, and people had access to all communal areas such as the activities room and dining areas.

There was no registered manager at the time of this inspection. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who registered with the Care Quality Commission 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.

The current manager had been in post at the service since November 2018. At the last inspection we were told that their position was not permanent and that they would remain in place until the provider had recruited a registered manager. Prior to this inspection, we were informed by the provider that they had successfully recruited a permanent manager, but they had yet to take up their position.

Kingsmead Lodge has not been operated and developed in line with all the values that underpin the Registering the Right Support and other best practice guidance. Kingsmead Lodge was designed, built and registered before this guidance was published. However, the provider has not developed or adapted Kingsmead Lodge in response to changes in best practice guidance. Had the provider applied to register Kingsmead Lodge today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs. People with learning disabilities using the service should be able to live as ordinary a life as any citizen.

Protocols, guidance and instructions for staff to support people living with epilepsy were contradictory and confusing; exposing people to the risk of receiving too much of a rescue medicine. There were unmitigated risks to people's safety around constipation and choking. There were significant shortfalls in the management and provision of fluids when providing support with people's hydration.

The themes and concerns we identified and raised at this inspection were also identified at the last inspection and in other inspections at other locations owned by the provider. This had not encouraged the provider to ensure improvements to the quality and safety of care provided to all people living at Kingsmead Lodge had been made.

The provider had not always ensured that people's consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005.

There remained gaps in training that had not been addressed since the last inspection. Some people displayed behaviours which may challenge others, yet not all staff had received specific training on how to manage such behaviours safely and effectively.

Although some changes had been made to improve systems and quality assurance processes to monitor and oversee care, there remained shortfalls in the reviewing of care plans, risk assessments and guidance for staff.

Care records did not always use appropriate language that respected people who were being supported.

Activities and occupation were not consistently person-centred. One activity observed did not promote people's independence or dignity. The provider had failed to utilise guidance from The Accessible Information Standard when supporting people to be involved with their own care. Care records did not consistently demonstrate people's health needs were being met. Opportunities had been missed to support people to communicate effectively.

People's nutritional needs were well met and they were supported to have enough food. There was enough food available and offered to people throughout our inspection at mealtimes and in-between. The menu offered flexibility to meet the needs of people and their specific dietary requirements. People had access to external health care professionals including GP's who visited the service weekly.

Staffing levels were sufficient to meet the care needs of people. The provider had safe and thorough recruitment practices in place to ensure that there were suitable staff to provide care.

People were able to receive visits from their relatives and friends whenever they wished at the service and staff knew people well. Staff had attended safeguarding adults training and knew how to protect people from abuse. Complaints were managed and responded to by the manager and the provider.

Staff ensured that equipment and the premises were maintained correctly and that measures were in place to mitigate risks and prevent infection.

People's care needs, in relation to their physical disabilities, had continued for the most part to be promoted through the environment of the service.

We found five breaches of Regulation and made one recommendation.

On 23 March 2020, we imposed conditions on the provider's registration telling them that they could not admit any service users into the service without the prior agreement of the Care Quality Commission. We also imposed a condition which requires the provider to tell us how they will address clinical oversight at the service, management of epilepsy and how they are responding to people's deteriorating health. The condition requires the provider to submit a monthly report to the Commission on their actions to improve in these areas.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

The overall rating for this service is 'Inadequate' and the service remains 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. At this inspection, the provider was in breach of five regulations of the Health and Social Care Act 2008 (regulated Activities Regulations 2014.

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 continued to be aspects of unsafe care and treatment that the provider had not addressed. There were continued risks to the management of people's hydration and constipation, while risks to people from choking remained.

The management of people's epilepsy needs was unsafe. Guidance and protocols for medicines and staff support were confusing and contradictory.

There were sufficient staff to manage people's care needs.

This is the providers third rating of Inadequate in the safe domain. Therefore, lessons had not been learnt to improve care practices.

Accidents and incidents were being managed proactively by the manager.

Is the service effective?

Inadequate

The service was not effective

The provider did not work consistently in accordance with MCA legislation.

People's needs were assessed prior to moving to the service and reviewed when needed. However, information and guidance was not always used in how risks were managed safely and effectively.

There continued to be some gaps in training. This included a lack of training to assist staff in managing behaviours which might challenge.

People's nutritional needs were met by staff.

People's needs, for the most part, were being met by the design and layout of the service.

Is the service caring?

Requires Improvement

The service was not consistently caring

Language used within care planning was not always respectful.

Confidential and private information within some care plans was not always appropriate and necessary for staff to have knowledge of.

People's independence was not always promoted by staff

We observed some caring interactions from staff who took time to interact with people in a compassionate manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Personalised care was not always delivered to people.

Improvements were needed to the activities and occupation provided to people. Information including care plans were not consistently in an accessible format to aid people's understanding.

Complaints were managed and responded to by the manager and the provider, although records were not consistently maintained. The complaints policy was not in accessible formats in line with accessible information standards.

People's complex communication needs were not always fully explored and supported.

Is the service well-led?

Inadequate

The service was not well-led

A number of breaches and continued breaches of Regulation were found. Themes around epilepsy, hydration, constipation, behavioural management, MCA and training had been highlighted to the provider but learning had not been successfully used to improve care at Kingsmead Lodge.

The service did not have a registered manager in place.

The provider had failed to put in place an effective and robust auditing system to identify, measure and improve the quality of the service delivered to people.

Care records were not always completed accurately. This included inconsistencies in responding accurately to people's health conditions.	

Kingsmead Lodge

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 was planned to check 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 comprehensive inspection took place on 28 and 29 January 2019 and was unannounced. This inspection was prompted by information we received and, in part, by a number of notifications the CQC had received. This information suggested that the concerns raised at the inspections in September 2018 and December 2018, in respect to the safety and quality of the service, had continued. The information shared within these notifications indicated potential concerns around the safety of people, the management of clinical risks and support, and of continued shortfalls in quality assurance systems and of the governance framework.

The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor had clinical experience in supporting people with complex heath needs.

Prior to the inspection, we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with two people who lived at the service to obtain their views of the care they received. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. To obtain these, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received.

We spoke to the acting manager, two registered nurses, two senior carer workers and a care assistant. We also spoke to six relatives of people living at the service. During the inspection, we observed medicines being administered to people. We reviewed records about people's care which included care plans of all ten

people. We looked at a range of clinical records as well as care and nursing notes, relating to the specific concerns we had received. We also looked at agency recruitment records and profiles, safeguarding records, accident and incident reports, quality assurance documents and medicines records.

Inadequate

Is the service safe?

Our findings

At the last two inspections carried out in September 2018 and December 2018, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all was reasonably done to mitigate risks to service users. At this inspection, while actions had been taken to mitigate and reduce the risks to people in areas of support such as maintaining skin integrity, we continued to find areas of concern that presented risks to people safety.

Some people required support to manage their complex needs associated with epilepsy, but protocols, guidance and instructions for staff were contradictory and confusing. This significantly increased the risks for people that they could receive unsafe, inconsistent support, as well as the possibility of being provided incorrect emergency medication. Sometimes people with epilepsy need special rescue medicines during a seizure. For example, the protocol for when to give one person a rescue medicine was lacking in detail and confusing, while the maximum dose to be given was conflicting with the use of a second dose. Another person with a diagnosis of epilepsy experienced seizures which were described as tonic-clonic, which if not treated correctly could lead to increased and prolonged seizures that required rescue medication. The care plan indicated the need for rescue medication if a seizure lasted longer than five minutes, and referred staff to the emergency protocol. The protocol indicated giving the rescue drug at 10mg should a seizure last longer than five minutes. It also instructed that a second dose could be administered if the seizure continued after ten minutes. The protocol stated that a maximum dose in 24 hours is only 10mg which contradicted the direction to give 20mg in two doses; and provided confusing guidance to clinical staff during a seizure. The person's medicine administration record (MAR) did not show that the rescue medicine had been prescribed for them at all, making the protocol invalid. No medicine should be administered without a prescription and it being documented on the MAR. This presented a high risk to the person should they experience a prolonged seizure. There was no risk assessment in place about managing the person's epilepsy. We brought this to the attention of the manager who told us that the error had already been brought to their attention. However, they had not acted on this immediately, leaving the person exposed to risk. The high number of agency staff used by the provider added to the risk as those staff would be less likely to know people's individual needs and the risks to them.

Risk assessments and care plans were in place for a third person for their epilepsy. The plans gave detail on the person's seizure type and known triggers. Protocols were in place for two different types of rescue medicines which could be given if the person experienced a prolonged seizure. However, the protocol for the use of one of these medicines had not been completed so there was only information for staff about one of the medicines to use. The decision about which of the two medicines to use depended on whether the person was able to take one of them by mouth during a seizure. The lack of detailed information about one of the rescue medicines meant staff did not have information needed to safely use this if necessary.

The risk assessment did not include measures to take in order to mitigate risk or provide a rapid response. Some people had not been fully assessed to identify the most appropriate aids or equipment to monitor their specific seizure type and risk, which would alert staff to any seizure activity. There were no risk assessments to identify aids that could help pick up unwitnessed seizures when people were in bed. The

manager told us that they had looked at specialist equipment but this had not been introduced. Listening alarms were present in people's rooms but would only pick up seizures if the person made noise during them or if the seizure caused excessive body movement.

Concerns about the management of people's epilepsy have been highlighted to the provider at a number of inspections of their other services. This information had not been effectively used to ensure that people living at Kingsmead Lodge received safe care and treatment. This demonstrated a lack of shared learning between the provider's services.

People living at Kingsmead Lodge had a learning disability, physical disabilities and some people had complex health needs. They were all fully reliant on staff to meet their needs. We found risks to people had been assessed but were not managed safely and consistently. For example, we found that the monitoring and management of some people's hydration needs was inconsistent. As a result, risks had not been identified or acted upon. Staff we spoke with were unclear about which people were at risk and who required specific monitoring and support with their hydration; which suggested that there was no clear assessment of risk to ensure people were appropriately and safely supported. One person, who was fully reliant on staff support, was assessed as requiring support to monitor their fluid, although this had not been followed up with specific actions on how this would be managed or monitored. A staff member confirmed that they did not complete fluid charts on behalf of the person. Therefore, staff did not have an accurate record of fluid intake, so would be unable to assess whether the person had drunk enough or remained at risk of dehydration. We raised these concerns with the management during the inspection. There were no audits completed that ensured appropriate oversight of people's hydration needs.

For another person, a constipation risk assessment had been completed and a care plan formulated that included a recommended daily fluid allowance (RDA). The daily records indicated that the person's fluid input was documented, but was below the RDA. The nurse told us that they did not record fluids given during medication administration. Some of the person's medication required dilution in water so amounts were not recorded accurately. Over a twelve-day period fluid charts showed the average fluid intake was markedly below the person's assessed RDA. It was also noted that the last recorded fluids received by the person were at 5pm with no further support noted until 9am the following day. There was a 16-hour gap between receipt of fluids. We looked at people's hydration support throughout the service and found an inconsistency in its application depending on which people required it. If fluid recordings were required, we were not always confident that levels were being recorded and that people's RDA were being met.

Risks associated with hydration have been found at inspections of a some of the provider's other services. This had not led to improved practices at Kingsmead Lodge.

We had previously identified, in inspections in September 2018 and December 2018, the continued risks associated with people's constipation and bowel management. At the last inspection, the manager had agreed that the guidance and recording systems in place were ineffective and informed us that a new monitoring chart would be devised and implemented. At this inspection, we found that while the manager had introduced a system of bowel charts, there remained gaps in some people's bowel management recording as well as conflicting and incorrect guidance for staff. The high number of agency staff used by the provider added to the risk as those staff would be less likely to know people's individual needs and the risks to them. We observed records that showed that some people's bowel management was being correctly supported, although there were gaps in other people's records that made it difficult to determine whether they were being supported safely in this area. For example, one person, whose assessment identified them as being at high risk of constipation, had a detailed elimination care plan in place, but this was not supported by a constipation risk assessment or a recommended daily fluid allowance (RDA). Other records

showed contradictory assessments and guidance for staff. For one person, guidance stated that GP support should be obtained if there was no bowel movement over a two-day period, although the care plan stated four days. When we alerted the manager to this error, they confirmed that neither guidance was correct and this should have been three days.

The lack of adequate constipation management has been highlighted as a concern at a number of inspections of the provider's other services. Despite this, we found that risks to people in this area remained at Kingsmead Lodge.

At the last inspection, we found that improvements had been made in the risk management and use of thickening powders for people who had difficulty in swallowing. Thickening powders are added to foods and liquids to bring them to the right consistency / texture, so they can be safely swallowed to provide nutrition and hydration to people. Assessments to mitigate the risks of people choking were clear in identifying what these risks were and how to respond in an emergency choking situation. The provider had recently introduced an airway-clearing choking device for staff to use in emergency situations. The manager and some staff confirmed that they had received training to use this device. However, we spoke to a senior carer who was unaware that the device was actively in use for people or where this device was located, while a registered nurse had no knowledge of the equipment. The impact of this was that senior or clinical staff, who would be expected to use this equipment in an emergency, would have been unable to do so in the absence of this knowledge. This increased the risks to people in situations when urgent and timely intervention would have been required.

The Resuscitation Council UK has issued a statement about airway clearing devices. They state that there is insufficient evidence about the safety and effectiveness of these devices and therefore they are unable to recommend them. It is the provider's responsibility to decide on what equipment they think will meet people's needs and seek advice accordingly. However, risk to people from choking should be properly mitigated and as some staff were unaware of the decision to use the device or knowledgeable about how to use it, people remained at risk.

Concerns about choking risks have been repeatedly raised with the provider through inspections of some of their other services. Our findings at Kingsmead Lodge showed that sufficient action had not been taken to reduce those risks.

The above evidence shows that not all was reasonably done to mitigate risks to service users. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There have been a high number of safeguarding concerns, and investigations, raised over the past year in relation to this service. Concerns were highlighted previously over the management of these concerns. At this inspection we found that the acting manager had been proactive in monitoring and evaluating any concerns as they emerged, and taking the lead in escalating these, where appropriate, to the local authority. The manager had worked closely with the local authority safeguarding team to identify, and mitigate, areas of concern resulting from these investigations. Staff we spoke to were knowledgeable about safeguarding issues and the different types of abuse.

We identified in this domain the concerns around the management of protocols for the administration of medicines when supporting people living with epilepsy. We have also detailed concerns around the auditing of medicines in the well-led domain. During the inspection, we spoke to the nurse in charge in detail around their knowledge of people's clinical needs and medicine management. We observed the administration of

medicines and this was undertaken correctly. They demonstrated a good working knowledge of MAR administration, National Early Warning Score (NEWS) and protocols. NEWS is a standardised system for recording and assessing baseline observations of people to promote safe and effective clinical care. The nurse sought consent where possible and explained to people that she wanted to give people medicines and acted in a kind and dignified manner. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

At the last inspection also found there had been a lack of consistency in the oversight and management of incidents and accidents. At this inspection the manager had ensured that there was a consistent reporting protocol in place and that actions from incidents were addressed in a timely manner.

At the last inspection, concerns were expressed by staff at the impact of the provider's decision to reduce the ratio of nurses on duty during the weekday shifts from two nurses to one nurse.The manager told us that they remained confident that this clinical staffing level was sufficient to meet people's needs effectively. The service's occupancy level had dropped since the last inspection and the manager told us that only three people were funded to receive nursing care and that the nursing ratios remained sufficient. The provider was also in the process of supporting some staff to become senior support workers. These are trained staff who would help registered practitioners deliver healthcare services to people. As an experienced support worker, they would carry out a range of clinical and non-clinical healthcare or therapeutic tasks, under the direct or indirect supervision of the registered healthcare practitioner. We observed people being supported in a timely manner throughout the inspection and there were sufficient levels of care staff to ensure that people received the support they needed. One relative told us, "I feel there is adequate staff, they seem to be well covered."

Risks associated with the safety of the environment and equipment were identified and managed appropriately. We saw records confirming the maintenance and checks of equipment such as hoists and wheelchairs. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Actions identified in fire risk assessments had been completed within agreed timescales to ensure continued compliance. Personal Emergency Evacuation Plans (PEEPs) were in place for each person, detailing the support they would need in the event of an emergency. Staff undertook fire response training and we saw evidence of regular fire drills that had been carried out successfully. We noted that the previous deputy manager was still named as the service's fire marshall. However, following the inspection the provider told us that all staff who had attended face to face fire training were automatically qualified as fire wardens. Daily handover sheets include information as to who the designated fire warden was for that day.

At the previous inspection we found that risks to people's skin integrity had not been fully addressed and implemented. At this inspection, improvements had been made to ensure that risks were identified and that there was clear guidance for staff on what to look for with regards to signs and symptoms of skin breakdown. Some people used bespoke sleep systems and had air mattresses in place to mitigate the risks associated with skin breakdown. Mattress settings were correct as prescribed for that person and skin integrity care plans and risk assessments outlined the signs that staff needed to look for in skin deterioration. Waterlow assessments had been completed in line with these risk assessments and had been reviewed monthly. Waterlow assessments are used to assist staff to assess the risk of a person developing a pressure ulcer. Skin barrier creams and prescribed topical creams were applied by staff during personal care. Records showed these had been applied when prescribed to maintain people's skin integrity.

At the last inspection, staff had not ensured that some clinical equipment was kept clean and stored appropriately to minimise the risk of contamination or infection. At this inspection, our observations showed that staff were ensuring that equipment and the premises were maintained correctly and that

measures were in place to mitigate risks and prevent infection. We observed using the appropriate protective equipment to ensure safe infection control.

Inadequate

Is the service effective?

Our findings

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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection on 3 December 2018, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured service users' consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. The provider had not always ensured that all people and their representatives had been involved in the process in their best interests. We also found that conditions within authorised DoLS were not always reflected in people's care plans. Management and staff were not knowledgeable of these conditions and therefore could not ensure that they were being met. At this inspection we found that, while the acting manager had identified issues and started to address them, a number of concerns still remained over the lack of oversight and management of the MCA and DoLS processes.

One person's DoLS authorisation had expired and the application to the local authority to ensure the safeguards continued had not been made prior to its expiry. Another person's authorisation had expired in August 2018 and the provider had failed to identify this. Although the manager took immediate action to submit an application to renew this, the provider had failed to have sufficient oversight of the DoLS process to ensure that authorised safeguards were in place for people and that any restrictions remained lawful.

At the inspection in December 2018, we had identified concerns over the assessment of capacity and best interest process for one person. Although steps had been taken to seek professional support for the person, the reassessment of their capacity and best interest process had yet to be developed. We also found that there continued to be a lack of understanding and joined up work from staff around the conditions attached to people's DoLS and their care planning. For example, one person had a condition on their DoLS that required clarity within their care planning about night time supervision. Although this was raised with management on the inspection in September 2018, nothing had progressed regarding formalising this condition within the person's care planning. Records showed a discrepancy between what was in the care plan around night time supervision and what was being delivered by staff. As a result of this the least restrictive option for the person and night time supervision had not been acted upon in their best interests. This was evidence that the principles of the MCA were not being followed in practice to protect the person's rights.

Mental capacity assessments had not been acted upon appropriately or reviewed. For example, MCA's for

medical preparation and treatment were completed for one person in September 2017 and had not been revised since that date. The best interest checklist stated, 'Best Interest discussion to be arranged' in November 2017 but there was no evidence this had taken place or been reviewed. Records of best interest decisions, people's capacity assessments and DoLS authorisations were held in different places in people's care records. This could be confusing for staff who would not know where to find a particular document to refer to. This was observed on a number of occasions during the inspection when staff had difficulty locating requested documents for the inspection team.

Failure to act within the principles of the MCA has been highlighted as a concern at a number of inspections of the provider's other services. Learning from this had not been appropriately shared by the provider to make improvements at Kingsmead Lodge.

The above evidence demonstrated that the provider had not ensured service users consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is the third time the provider had been in breach of this regulation.

At the last inspection, there was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not always received appropriate training to enable them to carry out their duties. At this inspection the provider had taken some steps to address some of the areas of concern, there were still gaps in staff training that had yet to be addressed. At the last two inspections in September and December 2018, some people at the service displayed behaviours that challenged. Records and staff feedback had confirmed that on occasions, these behaviours had led to physical aggression towards staff. A lack of training provided in PBS (Positive Behaviour Support) meant there was risk that incidents of a challenging nature would not be managed consistently and with a positive outcome for people. Although the provider had informed us in their action plan, following the inspection in September 2018, that PBS training would be arranged by January 2019, this had not yet been carried out. The manager told us that they felt that one person, identified within care plans as requiring support in this area, now exhibited minimal behaviours that challenged others. However, their care plan stated, 'I have episodes of physically and verbally aggressive behaviour and can at times be uncooperative and resistive to care. I am known to pinch and hit care staff and other people I live with'. This care plan had been reviewed monthly with no update that reflected an improvement. In addition to this there were records of an incident that had occurred since the last inspection where a person exhibited behaviour that challenged which staff were required to de-escalate. The incident was sufficiently significant that a safeguarding concern was sent to the local authority. Feedback received from one family member indicated that there were occasions when their relative became challenging and that staff needed to respond accordingly. This evidence demonstrated that there remained a need for staff to have the appropriate skills and training to ensure that they can successfully support behaviours that challenge and for plans to be reviewed to ensure that people were supported safely and effectively.

Shortfalls in staff training have been highlighted in inspections of a number of the provider's other services. This had not led to consistent improvements at Kingsmead Lodge.

The above evidence showed that staff had not always received appropriate training to enable them to carry out their duties as they are employed to perform. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns had been previously raised over shortfalls in the effectiveness of the induction provided to clinical agency staff. The acting manager had recently implemented more robust competency checks for both

agency and permanent clinical staff. We saw evidence that these had been completed in full. New registered nurses received assessments to ensure their competency and knowledge in areas such as the National Early Warning Score system (NEWS), percutaneous endoscopic gastrostomy (PEG) feeding and the administration of PR Paraldehyde, a liquid medicine used to treat seizures for people with epilepsy. The manager told us that these competencies were also to be carried out for existing nursing staff, although this had yet to be fully implemented across the service.

Significant concerns had been identified at the previous two inspections at the failure of staff to identify and escalate health support for people when their condition deteriorated. We found that staff were failing to implement the National Early Warning Score (NEWS) consistently or effectively, increasing the risks that people would not receive the required medical support. NEWS is a standardised system for recording and assessing baseline observations of people to promote safe and effective clinical care. The NEWS includes a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions registered nurses should take if checks show results outside of the baseline and a person's health deteriorates further. At this inspection we found that improvements had been made and that staff were using the system more consistently and effectively. Daily recording charts were being completed by support staff including the use of NEWS, while we saw this had been documented as part of physiological care plans. Registered nurses we spoke to had good working knowledge of how and when to apply NEWS recordings. The manager had also introduced NEWS competency assessments for new nursing staff as part of their induction. This was to ensure that they had the appropriate knowledge to effectively use the system prior to working in the service. They were also in the process of reassessing existing clinical staff.

At our last inspection, concerns were raised about the skills and competency of staff to effectively manage the PEG support people required. Change in occupancy levels had meant that at the time of this inspection only one person required PEG support. All nursing staff had now received training in this area, while some senior care staff had undertaken PEG training to support nursing staff with non-clinical PEG tasks.

People's physical, mental and social needs were assessed prior to them moving to the service. Information was used to develop care plans and guidance for each person that detailed their needs and how this care should be provided. However, information and guidance was not always used in how risks were managed safely and effectively. These areas have been highlighted in the Safe section of this report.

People's nutritional needs were being met by staff and people were supported to have enough food. Nutritional care plans that we looked at were detailed and informative and supported by advice and recommendations from a Speech and Language Therapist assessment. We observed people being supported by staff during a meal time in the recommended way. All the staff present in the dining area demonstrated a good knowledge and understanding of how they would support one person including the use of a thickener and fortified foods. Written menus were on a notice board to inform some people of the days cooked meals, although there was no pictorial or photos to aid people who were unable to read. We observed the chef bring the cooked meals on a hot trolley and spend time with each individual showing and telling them what all the foods were on offer, or if already prepared in a liquidised form, what he had prepared for them. There were several food choices of both main courses and puddings to choose from. The chef demonstrated a clear knowledge of people and their dietary needs.

Issues around the effectiveness and safety of one person's room layout were highlighted in the last inspection report. At this inspection the concerns about the layout of the person's room remained. Many people living at the service required the use of wheelchairs to mobilise around communal areas. Wide corridors and doorways and open plan communal areas allowed people to mobilise safely and freely. Bathrooms and bedrooms were equipped with the appropriate hoists and moving and positioning

equipment to ensure that people's needs were met safely.

Requires Improvement

Is the service caring?

Our findings

At the last inspection, the provider had not taken all reasonable measures to protect people from risk of harm. At this inspection, although some actions had been taken to address those specific areas, other concerns remained; where not all had been done to ensure people were protected from risk and harm. Therefore, a culture of caring values was not always evident across the service. We elaborated on these concerns in more detail in other sections of this report.

People's care plans did not always use respectful and appropriate language when providing instructions to staff on how to support them. For example, one person's behavioural care plan stated, 'There have been some occasions in (day centre) when I have misbehaved'. Another persons' care plan made comments about the person's truthfulness. Some care plans contained private information that was not relevant to staff. One care plan contained private historical details which staff did not need to know to be able to provide day to day care of the person. There were no outcomes or actions attached to this private information which would assist staff in supporting the person, therefore it was not necessary for staff to know this.

People's privacy and dignity was not always respected. On the second day of the inspection, three people were having their hair cut by a visiting professional in the main communal lounge. People were sat in front of others within the communal lounge to have their hair cut and this was completed one person after another. The process did not lend itself to dignified and private support.

People's independence was not always promoted by staff and we observed varying quality in practice. During lunch one person was using adaptive cutlery and a Manoy plate for their food. A Manoy plate is a dining aid that has been designed to make eating easier. It has a steep back edge that can be used to push food onto a spoon or fork and helps to support independent eating. We observed support staff taking the spoon from the person and feeding them directly. We asked staff why the person was not feeding themselves and they told us that staff preferred to feed the person because they "make such a mess". The person's care plan stated that they were to be encouraged by staff to feed themselves. This practice did not promote the person to be independent where they were able to be.

We observed other practices that showed staff looked to promote people's independence and choices. One person, who mobilised primarily with a wheelchair, was assessed as requiring support from staff to promote their physical wellbeing by encouraging them to walk regularly. Staff told us that the person felt most comfortable doing this at quieter times around the service, and we observed staff supporting the person to do this during a period when other residents were out in the community. Staff also ensured that the person was supported to make individual choices even when those choices involved a degree of risk. Their risk assessment highlighted the person's wish to wear comfortable shoes constantly against the need for them to wear orthotic boots to safely mobilise. The risk assessment promoted positive risk taking and acknowledged the person's right to make certain choices against their limited understanding of health and safety issues. Staff had reached a compromise with the person by ensuring that they supported them to change into their favourite footwear when mobility sessions had ended.

Most people were not able to tell us about their experiences. We carried out a number of observations throughout the two days of the inspection to observe people's reactions, interactions and responses to staff support. We observed a number of positive staff interactions with people that indicated they felt safe and comfortable in their presence. We observed One person was laughing from playful interactions with one staff member as they passed them. The staff member was clearly aware of the person's enthusiasm for interaction and they demonstrated this naturally. We observed staff addressing people who used wheelchairs by bending down to ensure they were at eye level with the person when they spoke. When providing support to people, we saw staff explaining slowly and clearly what actions they were taking to support them. During lunch, staff took their time and made sure people they were supporting to eat had time to swallow and drinks offered in between. One person showed signs of distress and the support staff sought help immediately from the nurse and stopped the feeding activity. Relatives told us that staff were knowledgeable and caring towards their family members. One relative told us, "My relative has the same key-worker who seems very knowledgeable and caring." Another family member said, "Even when I'm visiting the staff don't know I'm observing them, they are so good, it's as if they are looking after a member of their own family."

People's rooms were personalised and decorated to a good standard with various items and pictures, important to that person, displayed around the rooms. It was clear what people's personal interests and likes were from the décor that they had been supported to arrange. This created a familiar environment for people to live in.

Staff ensured that bedroom and bathroom doors were closed when they provided personal care. They knocked on people's doors before entering. We observed this practice even when people's doors were open and they could see the staff member was approaching. Relatives told us that they felt staff respected their family member's right to privacy. One family member told us, "With regards to my relative's personal care, staff always shut the door, and also if my relative wants to speak to staff in private, she can." Another relative told us, "Staff always treat (family member) with respect."

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection in September 2018, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because personalised care was not consistently provided to all service users. At this inspection, there were continued shortfalls in ensuring that people's needs, especially when these had changed, were accurately reflected within care plans.

At the last comprehensive inspection in September 2018, further work was required to ensure that activities were personalised for all people living at the service. At this inspection we found that people could still benefit from more personalised activities and occupation. Activities were not always person centred and records showed that people were not always supported to engage in the activities stated within their care plan. For example, one person's activities care plan stated, 'I do not like the following activities: Arts and Crafts and Board games', yet their timetable included two morning sessions of Arts and Crafts and one full day of games. Daily activity records confirmed that on multiple days this person received 1:1 but it did not specify what activities, if any, they were being supported with. One staff record stated, 'I asked (person) what he would like to do, but did not get an answer'. There were no entries to confirm that the staff member had initiated any activities to stimulate interest. We asked the senior carer who was providing the person's one-to-one support what occupation they engaged the person in. The person spent a high proportion of their time in their room being monitored. The staff member showed us cards that the person liked to sort and look at, but had to search for other items within a box for additional items they stated the person liked to use. Our continuous observations over the two days of the inspection did not support that the additional items were being used with the person.

There continued to be missed opportunities for activity outside the service. Activities such as people having haircuts, as detailed in the caring section of this report, did not lend itself to the provision of personalised support. We raised the issue with the acting manager over the task led approach and questioned whether support could have been arranged so that people could go into the community to experience this. The acting manager and area manager agreed that this process could be more personalised and agreed to consider providing more individual approach for people. In the lounge, up to three people at a time were placed in front of the communal television while a political news programme played for a number of hours. The activities assistant told us that they felt that having such programmes available provided some form of mental stimulation to people. However, this was misjudged assessment of the needs and abilities of the people they were supporting, who may have benefitted from stimulation through more appropriate personalised activities. There was no engagement by people with the programme. As some residents were attending day centres there were sufficient staff to have spent time with people to engage in meaningful activities they enjoyed.

The provider had not always ensured that people's needs, and changing needs, were reflected within care plans to ensure they captured their needs accurately. We have detailed examples of these in the safe section of this report.

Care plans were completed in a written format. These were applicable for many people at the service, but not others. We found that the provider had not fully considered or implemented the guidance within the Accessible Information Standards (AIS). All providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard in full from August 2016 onwards. This means they must, identify, record, flag, share and meet the information and communication needs relating to people with a disability, impairment or sensory loss. The provider had identified people's different communication needs, in line with these standards, but had not always assessed how information should be recorded or shared with the person in an accessible way that met their communication needs. Reasonable adjustments had not always been made to ensure that people's information needs had been identified or consistently met. For example, one person's AIS document confirmed that they used verbal communication and pictures yet this was not considered within care plans or risk assessments. Not all had been reasonably done, to support people to communicate effectively.

In October 2015, national guidelines were published in relation to supporting people living with a learning disability and/or autism, under 'Building the Right Support'. The guidelines talk about the support people need to enable them to live the lives they choose and that services should be more person-centred. The Commission published a policy in June 2017 regarding the new registration of services supporting people with these defined needs. Kingsmead Lodge, was registered prior to this guidance being published. Nevertheless, we would expect providers of existing services to develop plans and strategies on how they will provide, improve and enhance the lives of people they support, to enable them to live meaningful and fulfilling lives. The findings of our inspection reflect that people did not always receive the consistent care and support they needed and were entitled to, to ensure they received high quality, compassionate care. This included a lack of evidence that all people consistently received personalised activities as most were generic in nature and often aimed at the group rather than the individual person.

The above evidence demonstrates that the provider had failed to ensure that people received care or treatment that was personalised specifically for them. This is a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were managed and responded to by the manager and the provider. A complaints policy was in place but this was not available in accessible formats in line with accessible information standards. We saw records of two complaints dealt with by the manager and by head office. Records of the management of the complaint had not been updated, although the manager informed us of the steps they had taken to resolve the complaint and actions they had taken to mitigate any further risks. We were told that a meeting between management and the complainant had resolved the issue and the complainant was satisfied with the response. However, records had not been made to demonstrate this. Relatives confirmed that they had raised issues with the provider and that these had been resolved.

We recommend that the provider ensures that appropriate and accurate records of complaints management are maintained.

At the time of the inspection there were no people at the service receiving end of life care. Discussions had taken place with people and their relatives about their wishes and preferences for support at the end of their lives and this was documented in their care plan. However, there was conflicting information and guidance recorded for one person's end of life decisions. The person had an end of life care pathway and a detailed care plan in case of clinical deterioration. There were two care plans for their end of life wishes that contained conflicting information regarding resuscitation which could lead to confusion in the event of an emergency. The manager had identified the conflicting information and a referral to an advocate had been made.

We spoke to the activities assistant about how the service facilitates support for people. They confirmed that the activities coordinator had left their post just prior the inspection and that a review of activities with the acting manager was planned. The activities assistant told us that they had started to support people with activities that promoted physical movement to improve motor function. The staff member stated that this was in response to their observations that people had few opportunities for physical movement in the group activities being provided. With the support and guidance of a physiotherapist, the assistant told us that they had observed progress with one person who displayed a reluctance to release items from their grasp. With support, staff had supported them to improve their hand and arm coordination to release objects and participate more in physical activities. People engaged happily in a group singing session on the first day of the inspection, while the external entertainer was proactive in ensuring each member of the group participated.

Inadequate

Is the service well-led?

Our findings

At the last inspection in December 2018 we found that people were not being provided consistent safe care and treatment. CQC had received information throughout October and November 2018 that suggested that the care that people received had not improved and that concerns around the effectiveness of staff's response to people's needs and changes to their health remained. At that inspection, the provider was in breach of four regulations and rated Inadequate overall.

At this inspection we found a number of areas that continued to show little or no improvement. There was a continued failing to ensure that some risks to people were mitigated effectively to ensure they received safe and effective care. Concerns were raised over the risks relating to the lack of guidance and management of people's epilepsy and an inconsistent and potentially unsafe management of people's hydration and constipation. Concerns continued around the oversight of Deprivation of Liberty safeguards and a failure to act within the principles of the Mental Capacity Act.

There were continued breaches of Regulation 9, Regulation 11, Regulation 12, Regulation 18 and, as detailed below, Regulation 17 of the Health and Social Care Act 2008 (regulated Activities Regulations 2014).

Themes have been identified across the provider's services which have been highlighted to them as of significant concern. Many of these themes have been identified at Kingsmead Lodge, for example the management of epilepsy, hydration, constipation, behavioural management, training, and MCA/DoLS. Despite these themes having been repeatedly raised with the provider, learning from them had not been successfully or effectively shared or used to drive forward improvements at Kingsmead Lodge.

At the last inspection evidence showed that the systems and processes of quality monitoring and governance in place were not consistently effective and the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a failure to assess, monitor and improve the quality and safety of the services provided. At this inspection, we found that while the acting manager had made some improvements to the systems that monitor the quality of the service, there remained significant shortfalls in the quality and safety of care.

The concerns highlighted within the safe and effective domains of this report demonstrate that the reviewing and monitoring of people's care plans and guidance had not always been undertaken effectively. This meant that incorrect or conflicting information for staff had not been identified and changed. For example, we found an elimination care plan for one person that indicated they were at a high risk of constipation, but this was not supported by a constipation risk assessment. Another person's elimination care plan gave conflicting information about how they should be supported, but this had not been identified through care plan reviews. Epilepsy protocols that lacked detail and gave conflicting information on medicine administration had not been identified through previous medicine audits and reviews. Protocols for the use of one person's nebuliser were in place, but no associated care plan.

We identified and raised concerns with the management team about the oversight of people's fluids,

detailed in the safe domain. We highlighted where specific recommended daily allowances had been calculated for a person at risk of urinary tract infections but where fluid intake was consistently calculated to be well below this RDA. The manager confirmed that fluid charts should have been in place. There was no oversight or governance that demonstrated these issues had been previously identified and that risks had been identified and mitigated appropriately.

Although concerns had been raised with the relevant management teams in the previous two inspections, we continued to find shortfalls in the management and oversight of the MCA/DoLS process. There was no auditing system in place to ensure that applications to safeguard individuals were reviewed, and for reauthorisation applications to be made to the local authority before they expired. Mental capacity assessments and best interest decisions had not been reviewed in line with the provider's stated timescales.

The provider had failed to utilise guidance from the Accessible Information Standard when supporting people to be involved with their own care. We raised this with the provider at the last comprehensive inspection in September 2018. People's communication needs had been assessed but there had been little consideration of accessible formats. AIS were noted in people's care plans but these had not been reviewed or acted upon which meant that opportunities had continued to be missed to support people to communicate effectively.

The acting manager had ensured that weekly checks and monthly medicine audits were now being undertaken. Audit checks monitored the quality of staff's administration and medicine management. Shortfalls in administration, and gaps in recording, were highlighted within these checks, while the resulting actions were recorded for management to address. However, one weekly check had identified six separate occasions when MAR had not been signed by nursing staff after administering medicines. In the 'actions to be taken' section, it was recorded that 'signatures missing on MAR charts' with no indication of why these errors had occurred, or what had been done to address this. Auditing records also indicated that nursing staff were required to complete a ten-point MAR check at every medicine round, as part of the quality assurance process. The monthly audit had identified that these were not always being completed sufficiently and stated 'Few gaps on check, very messy. Not sure if checks been carried out as not ticked'. As identified in the safe domain, quality assurance checks had failed to identify that one person's epilepsy medicine was not recorded as a prescribed medicine on their MAR charts. This concern was brought to the attention of the manager who confirmed that they were aware of the issue and were taking action to rectify it. However, this had not been acted on immediately despite the manager being aware of the issue, and highlighted concerns that the mitigation of risks to individuals was not always being prioritised.

Kingsmead Lodge receives monthly reports from the provider's regional team which detail feedback from discussions with people and staff as well as reviews of complaints and the safety and quality of the service. The report also records the status of both internal and external audits undertaken at the service. The most recent report confirmed that the last internal quality assurance audit by the provider was completed in May 2018, despite the high level of concerns raised by the CQC and the local authority throughout 2018 until present. The January 2019 assessment of the internal quality assurance audit completed in May 2018 indicated that they 'could not find evidence of actions being completed however'., This showed that there had not been an adequate governance framework in place to ensure that required improvements had been addressed in a timely manner.

The above evidence continues to show that the systems or processes in place were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. This is the third inspection that the provider has been in breach of this regulation.

At the last inspection on 3 December 2018 the service did not have a registered manager in place. The service has been without a registered manager since February 2018. In the interim period, the service had been supported by a number of managers, and was, at the time of the inspection undertaken in September 2018, being managed on a day-to-day basis by the deputy manager. Following the inspection in September 2018 another manager was recruited by the provider, but was in post for less than a month. At the last inspection in December 2018, the provider had employed a peripatetic manager who had been in post since late November 2018. The manager informed us that they had had a very limited handover with the outgoing manager. There had also been changes to the operational oversight of the service with a change to the regional operations manager supporting the service. Prior to this inspection, we were informed that the provider had conducted successful interviews for the registered manager and deputy managers positions although start dates had yet to be confirmed. Following the inspection, the provider informed us that the new manager was in the process of registering with the CQC.

The failure to have a registered manager is a continued breach of section 33 of the Health and Social Care Act 2008.

The acting manager informed us that she had prioritised improvements where they felt risk was highest and had taken steps to address the areas highlighted by the CQC and from the provider's own internal assessments. Our discussions with the acting manager confirmed that there was a good awareness of the specific improvements that were needed and that the focus should be on areas where risks to people were highest. The evidence within this report highlights that, while progress had been made in some areas, action had not always been taken in a timely manner to identify and mitigate where risks to people were highest. The absence of a deputy manager at the service had meant that the majority of day-to-day management tasks were being undertaken solely by the acting manager. The manager told us they were focussed on upskilling existing staff. We were told that one senior was to be delegated some responsibility for care planning when they had completed relevant training. Currently the responsibility for managing and improving care planning was shared between the manager and nursing staff, although the manager indicated that some agency nurses did not have the competency levels to complete this task. The manager also indicated that provider level quality assurance systems had not been entirely effective in identifying and actioning the necessary shortfalls. This evidence showed that the acting manager was addressing the critical issues, but there was not sufficient evidence of structured support around the manager to make the improvements in an effective and timely manner.

The acting manager had also introduced auditing tools to monitor nursing staff's use of the National Early Warning Score (NEWS) system. We looked at two NEWS audits which had identified that a physical condition care plan was not available to record people's baseline observations, and had recorded actions to improve this. This system had not yet been embedded in the service's quality assurance system, so we were unable to ascertain how effective this was. The identification and escalation of support when people's health had deteriorated, had been a significant concern at the service over the last two inspections.

Relatives we spoke with said that staff communicated with them about the needs and progress of their family members. They told us that they were supported to voice their opinions and participate in their family members support. One relative told us, "We get copies of any correspondence and we are happy with the level we are consulted." Quality assurance surveys were sent out by the provider to relatives for them to feedback their opinions about the support given. Two relatives told us that they had been invited to a provider meeting in December to discuss the ongoing concerns at the service and to provide assurances

about what the provider was doing.

The manager had been proactive in liaising with health professionals and other agencies. Concerns raised at the last two inspections had required reviews of people's clinical needs and the manager had actively sought professional input to address these concerns.

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
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Personalised care was not consistently provided to all service users.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not consistently working in accordance with the MCA legislation.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were failings regarding how risks were mitigated on behalf of service users. This included epilepsy, constipation and hydration.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of robust and effective checks made on the quality and care provided to service users. This included a failure to improve from previous inspections.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training had not been provided to support staff to manage behaviours which may challenge others.

The enforcement action we took:

We imposed a condition on the provider's registration.