Lifeways Inclusive Lifestyles Limited

The Duke's House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Duke's House is a residential care home providing accommodation, support and personal care for people who have a learning disability or autistic people. At the time of our inspection seven people were living at the home; the home can accommodate up to eight people. The home is in a residential area of New Brighton, across two three story Victorian properties which have been joined. Each person has a private en-suite room. There are communal lounges, a dining area, an accessible kitchen and office space on the ground floor.

At our previous inspection three people were living at The Duke's House whilst building work was taking place. Following the renovations, five people moved into the home from the providers other homes as part of a remodelling of their services.

People's experience of using this service and what we found
The service design and environment did not meet all people's needs as outlined in their support plans. Some people's known actions were those that caused upset and were likely to get a negative response from other people in the home. Our observations and feedback from health and social care professionals, people's family members and staff; confirmed that the combination of these risks and the atmosphere they created was having a negative impact on people's wellbeing.

There were enough staff to meet people's needs. However, staff members told us that at times there was not always enough staff available to support people; and this has had a negative impact on people being able to do things they wish to do.

People's family members, staff and outside health and social care professionals told us that there had been a very high turnover of staff and the staff team had remained unstable since our last inspection. One health and social care professional told us, "Staff turnover is massive." Making effective improvements based upon learning from incidents and feedback from people; had been hindered by a high turnover of senior staff, high turnover of support staff and a lack of stability within the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

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

Right support:
• The model of care and setting did not meet all people's needs or maximise positive outcomes for them.

The model of accommodation did not promote people living an ordinary lifestyle.

Right care:
• Staff were caring and kind towards people. However, people's care was not always provided in a person-centred way, based on what was important to them. People's family members told us the provider had not worked in partnership with them in a meaningful way.

Right culture:
• There had been an extended period of change within staff teams and change of leaders within the service. Staff members described fractured teams. Health and social care professionals and people's relatives criticised the provider's communication and partnership working. Some people's relatives told us they thought the provider needed to rebuild relationships and trust with them.

There was a system in place for recording and reviewing any safeguarding concerns. Referrals had been made to the local authorities safeguarding team. People and their family members told us they felt safe with staff members, who treated people well.

Managers and staff had responded appropriately to the COVID-19 pandemic. People supported each had a COVID-19 risk assessment and management plan in place.

There was a new home manager in place who was making an application to be registered with the CQC. At the time of our visit they had been in post for five weeks. Staff members described the new manager as approachable and in their initial time at the home they had promoted some new ideas that included people living at the home. One staff member commented, "Things appear more organised and friendly." These were very recent changes which would need to become embedded into the service to enable staff to be effective in supporting people.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 September 2020). The service remains rated requires improvement. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been rated requires improvement or inadequate for the last three consecutive inspections. This service has been in Special Measures since April 2020.

Why we inspected
This was a planned inspection based on the previous rating.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Duke's House on our website at www.cqc.org.uk.

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.

We have identified breaches of regulations in relation to providing person-centred care that was appropriate, met people's needs and reflected their preferences. In relation to good governance, the provider had failed to assess and monitor the quality of the experience of people who received those services; and had not effectively sought and acted on feedback.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
This service has been in Special Measures since 3 April 2020. This was following an inspection that rated the service as 'Inadequate' overall. Following our inspection, the provider proposed to remodel this service as part of a wider program of change. In September 2020, in line with our methodology we inspected again within six months of the publication of our public report. We were aware that this was in the middle of the providers change program, during which most people had moved out of the home. This meant that at the time of our inspection only three people were living at The Duke's House, only part of the building was being used and building work was taking place.

In September 2020, most of the planned changes had not yet taken place and a further five people were due to move into the home. Therefore, we completed a focused inspection of the key questions, safe and well-led to ensure people's safety. However, the ratings for other key questions were not reviewed and the service remained in special measures.

At this inspection the overall rating for this service is 'Requires improvement'. The service remains in special measures because it continues to be rated 'Inadequate' in one of the five key questions. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Duke's House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
The Duke's House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Since our last inspection in September 2020 the registered manager had left. The service has a new manager who was not registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from local authority professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with and observed the support of five people who used the service. We spoke with eight members of staff including the area manager, home manager, deputy manager, support staff, activities co-ordinator, chef and housekeeping staff. We reviewed a range of records. This included three people's care records in depth and four people's support plans as an overview. We looked at multiple medication records; and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff recruitment records and additional care plans. After our visit we spoke with seven people's family members, seven members of staff and three health and social care professionals by telephone.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection we recommended the provider review the health and safety systems with regard to the home's environment. At this inspection the environment was safe and free from hazards.

● The impact on people of some risks had not been fully considered. Each person had individualised risk assessments and support plans which included details about risks they may pose to themselves and others. However, we did not see how the overarching risk of people who may pose a risk to themselves and others, sharing accommodation and communal areas was assessed and managed. Some people's known actions were those that caused upset and were likely to get a negative response from other people in the home.
● When a person who is known to pose risks to themselves and others, is to live and share long term accommodation with other people; careful planning and consideration of compatibility, risk and sustainability needs to take place. We found that the provider had not given sufficient consideration to the compatibility of people living together.
● Our observations and feedback from health and social care professionals, people's family members and staff confirmed that the combination of these risks and the atmosphere they created was having a negative impact on people's wellbeing.
● We saw records showing and staff told us there was a reliance of staff physically intervening to prevent actual conflict between people living at The Duke's House. One staff member said, "Sometimes we spend the whole day stopping people clashing and fighting."
● One health and social work professional told us of their surprise when they became aware of the assessed needs of, and the mix of people living at the home. Another told us, "Due to the environmental and house dynamics it is often necessary to take residents out to relax [or] reduce anxiety… the home should be a place of safety whereas this does not feel to be the case."

This is a repeated breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In planning and providing support and accommodation for people; the provider had failed to assess, monitor and improve the quality and safety of the services provided; including assessing the experience of service users who received those services.

● Steps had been taken to adapt areas of the home to help promote people's independence safely. There had been an improvement in the safe management of food preparation and kitchen areas.
● Some risk assessments and support plans had been effective, for example, one person told us they had been involved in putting together and agreed with their risk assessment and support plan. They explained

that they knew the aims of these and the benefits to them. Staff had been trained in how to support people in ways that reduced these risks.

Staffing and recruitment

● There were enough staff supporting people to meet their assessed needs. On the day of our unannounced visit there were nine staff supporting people. This matched the rota and the assessed hours to meet people's needs. The local authority quality improvement team who had been working with the provider told us there had been some recent improvement in staffing levels.

● Staff members told us at times there has not been enough staff available to support people; and this has had a negative impact on people being able to do things they wish to do. One staff member told us at times they have to prioritise supporting people to go out who are becoming anxious.

● People's family members, staff and outside health and social care professionals told us there had been a very high turnover of staff and the staff team had remained unstable since our last inspection. One health and social care professional told us, "Staff turnover is massive." One family member told us, "[Name's] behaviour is exacerbated by staff change." Another family member told us staff turnover was, "Worrying."

● The provider had a centralised system across their services to ensure that new staff were recruited safely in line with regulation.

Learning lessons when things go wrong

● The provider making effective improvements based upon learning from incidents and feedback from people; had been hindered by a high turnover of senior staff, high turnover of support staff and a lack of stability. Senior staff had been unable to plan and implement long term solutions. They have been mitigating and managing problems, rather than working with people and their families to identify and solve them. One person's family member told us about staff support, "We feel we are getting somewhere, and then they leave."

● At our last inspection we recommended that the provider continue to assess themselves against the principles of Registering the Right Support; these included the values of choice, control and independence when providing care and accommodation for people. At this inspection the service continued to not meet the principles of the current guidance Right Support, Right Care, Right Culture and its predecessor Registering the Right Support.

Using medicines safely

At our last inspection we recommended the provider consider current guidance for maintaining medication records and take action to update their practice. At this inspection medication records were well maintained.

● People's medication was administered safely by staff who had received training and had their competency in administering medication assessed. Medication was stored safely with regular checks made on safe storage temperatures. Staff had access to the providers medication policies and appropriate guidance. Managers had completed audits of the medication system.

● Each person had a medication profile which provided guidance for staff, including their preferences on how to take their medication. This guidance included advice from medical professionals on the most appropriate use of as and when required (PRN) medication; and guidance on what support people may need before making the decision to administer medication.

● We checked a sample of medication administration records; these were correct, showed that stocks were correct, and staff followed individualised guidance when administering PRN medication.

Systems and processes to safeguard people from the risk of abuse

● The provider took steps to safeguard people from the risk of abuse. Staff had completed training regarding safeguarding adults who may be at risk of abuse. Staff members had a good understanding of some indicators and clues of abuse and the procedures in place for raising any concerns. There was a whistleblowing policy in place. We saw evidence that staff were comfortable raising any concerns they may have.

● There was a system in place for recording and reviewing any safeguarding concerns. Referrals had been made to the local authorities safeguarding team.

● People and their family members told us they felt safe with staff members, who treated people well.

Preventing and controlling infection

● Managers and staff had responded appropriately to the COVID-19 pandemic. People supported had a COVID-19 risk assessment and management plan in place. Staff told us they felt safe at work and were provided with good stocks of appropriate personal protective equipment (PPE). Staff said they had received training in infection prevention and control and the use of PPE.

● The home was clean and well maintained. There were housekeepers who followed cleaning schedules and maintained cleaning records, including regular cleaning of high contact areas. One housekeeper told us they were supported in their role and had received relevant training.

● People family members told us as much as possible people had been well supported to stay safe during the pandemic; they praised the actions of staff members during this difficult time. People's friends and families told us they had been supported to visit people safely. An appropriate visitors' room for people to use had been set up. Visitors were tested using a rapid lateral flow test (LFT).

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. There had been improvement in many aspects of the effectiveness of the care and support provided for people. However, at this inspection we were not assured that the environment met people's needs and preferences. At times the design of the service did not enable staff to provide effective support for people, that supported them to achieve good outcomes.

Adapting service, design, decoration to meet people's needs

At our last inspection of the key question, 'Is this service effective?' The provider had not ensured the home's environment met people's needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there had been improvements made to the home's decoration and refurbishment. However, the design of the service still did not meet some people's needs. The service remained in breach of Regulation 9.

- The service design and environment did not meet all people's needs as outlined in their support plans. At times there was a complete contradiction between people's assessed need and the design of the service.
- Current best practice is for long term shared accommodation to have a small scale and domestic feel; it should take into account people's preferences and any specific support needs or risks. This includes assessing the impact of environmental factors on a person and their experience.
- Staff and some people's family members described a busy and noisy atmosphere that did not benefit everybody living at The Duke's House and how the location of some people's rooms did not meet their needs. Some staff and family members described and there was records that showed the design and layout of the environment at times had a negative impact on people and contributed to their anxiety, being upset and spending increased time in their rooms. One family member said, "Noise really gets [name] down. Paint and decorate all you like; it is still a bit institutionalised… It is bigger than it should be to make it homely."
- Staff members described how they felt the environment within the home was overwhelming for some people; and at times there was too many people present. Staff told us at times people were supported away from the home's communal areas, to the garden or out to other areas to prevent them being upset. One staff member told us, "I like to be free and roam around my house; like none of them are able to do. I think this makes people more anxious." One health and social care professional told us, "The house environment is not a relaxed one."
- People's family members told us they had not felt involved in the designing of the service. One family member told us, "There was little thought about our input."

This is a repeated breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. The provider had not ensured the design of the service was appropriate, met people's needs and reflected their preferences.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection of the key question, 'Is this service effective?' The provider had not ensured people's fundamental rights were acknowledged and protected. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made and the provider was no longer in breach of Regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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 now had oversight of people's care and support being provided in line with their legal rights.
● The provider and senior staff held accurate and up to date records of any authorised DoLS in place. Any restrictions in place and the level of support people received had been deemed necessary, and in line with people's best interests.

Staff support: induction, training, skills and experience

At our last inspection of the key question, 'Is this service effective?' Staff had not received appropriate support and training to enable them to be effective in their role. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made and the provider was no longer in breach of Regulation 18.

● Staff told us they received appropriate training to enable them to be effective in their roles. Staff also told us they received training in how to deescalate situations and provide appropriate support to help people remain safe when anxious. One staff member told us, "This training was good." Another told us, "At the start of the role I felt ready."
● Records from the provider showed that a reasonable percentage of planned training for staff had been completed; with a plan in place to fully complete the training programme. Staff described to us on-line training that they had received during the pandemic and they had opportunities to read people's care and support plans.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support

● The provider has not always worked effectively with other agencies. Some healthcare professionals described difficulty in obtaining accurate and up to date information regarding ongoing monitoring of any changes to people's health. Both healthcare professionals and people's family members told us the high turnover of staff had meant that people's support with their healthcare had not been as effective as it needs to be. Some healthcare professionals and people's families told us there had been a recent improvement in this.
● Some face to face appointments had been suspended due to the pandemic; however, there was evidence of health professionals being involved by remote means. Essential health appointments were still taking place.
● When possible, people were being supported to be as independent as possible in managing their own healthcare needs was promoted.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had assessments in place that outlined their choices and opinions. We saw these had periodically been reviewed. Since our last inspection covering this domain in December 2019; there had been restrictions on people's choices during periods of national COVID-19 restrictions. We saw that within the confinements of the home's environment and pandemic restrictions staff had taken day to day steps to support people in line with their needs and choices.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to have a balanced diet. Each person had a support plan to help ensure they enjoyed a balanced diet that safely met their needs. Support plans recorded people's food and drink preferences. If needed people's eating and drink support plan, provided guidance for staff on recording and monitoring people's diet.
● Between Monday and Friday there was a chef in place. The chef told us they plan meals ahead with people but will also try their best to accommodate people's requests if they change their mind. Staff were provided with a meal when supporting a person; we were told by the chef that this helps to create a nice atmosphere when people and staff are eating together.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; continuous learning and improving care

At our last inspection, the provider's assessing of the quality and safety of the service provided for people had not always been effective. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the service remains in breach of Regulation 17.

- The provider had not ensured that the service provided for people was meeting the principles of right support, right care, right culture. There was evidence from our observations, records, feedback from staff, people's relatives and health and social care professionals; that the design of the service and environment was not meeting all people's needs, preferences or helping to promote positive outcomes.
- The Duke's House is intended to be people's long stay home. The environment is larger than most domestic settings; at times with people supported and staff there can be up to 20 people in the building. Some people's support plans described the desired environment being quieter and relaxed. It was recognised in some incident reports that this environment had contributed to people being upset. Some people's relatives told us this is not the design of service they thought matched the needs of their family member. Some health and social care professionals had concerns about the decisions the provider had made, regarding the combination of people who had moved into the home.
- There had been a continued period of instability at the home, leadership remained inconsistent; there had been multiple changes of senior staff at the service since our previous inspection.
- Staff feedback about morale and the atmosphere within the service was very mixed. Most staff told us that staff did not all have good relationships with each other and this at times had a negative impact on the atmosphere within the home.
- This is the third inspection were the overall rating has been inadequate or requires improvement. There are themes of the areas requiring improvement across all three inspections regarding communication, stability of leadership and staff teams, the staff culture within the home, working in partnership with people's families, working in partnership with health and social care professionals; and providing accommodation and support that meets people's needs and preferences.
- Whilst some changes and improvements have been made, these had not always been effective. The provider has not shown a positive culture of learning and continuous improvement.

This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not effectively assessed, monitored and improved the quality of the services provided for people.

● People's care plans and records recorded by staff were more respectful of people in their tone.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others

● The provider had not effectively worked in partnership with others. Most people's family members told us that the communication by the provider and their representatives had been poor. They described a lack of effective communication that had contributed to stress; particularly during the lockdown periods.

● Health and social care professionals and family members told us about long term problems with the homes phone system and people at the home being able to obtain access to the internet. Family members told us of having to put their own work arounds in place to help them remain in contact with their family members. One family member told us, "It is horrendous getting through." Professionals also told us of social workers having difficulty communicating with the service.

● One family member told us, "If they would improve their communication, I'd feel a lot safer." Another told us, "Communication is terrible, I don't feel involved." A third said, "I just want them to be their best… if they would just include parents in this place."

● Some family members told us that due to a period of poor communication, they feel trust needs to be rebuilt with the provider organisation.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not effectively sought and acted on feedback from relevant persons and other persons; for the purposes of continually evaluating and improving the service provided.

● In day to day matters we saw that staff communicated with people in a manner meaningful to them. We saw that some people had extensive and detailed communication support plans which used visual aids to help ensure staff understood people.

● Staff told us there had been some recent improvements in communication. For example, they had daily staff briefings to help improve information sharing and communication.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There is a new home manager in place who is making an application to be registered with the CQC. At the time of our visit they had been in post for five weeks. Staff members described the new manager as approachable and in their initial time at the home had promoted some new ideas that included people. One staff member commented, "Things appear more organised and friendly."

● Staff described recent improvements in internal communication. Staff members told us that the new manager had introduced shift handovers. Written records were kept of these handovers, these included any information that the next group of staff would need to be aware of to help them be effective supporting people.

● These were positive changes. However, these were very recent and would need to become embedded into the service, to enable staff to be more effective in supporting people.

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

● We have asked the manager to review some recent incidents at the home against the criteria for notifying

the CQC.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that the design of the service was appropriate, met people's needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance In planning and providing support and accommodation for people; the provider had failed to assess and monitor the quality of services provided for people; and the experience of service users who received those services. The provider had not effectively sought and acted on feedback from relevant persons and other persons; for the purposes of continually evaluating and improving the service provided.