Sense

SENSE Tanglewood

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

About the service
SENSE Tanglewood is a residential care home providing personal care to up to 7 people. The service provides support to people with sensory impairment. At the time of our inspection there were 6 people using the service. The service is provided in a large, detached home in a residential area.

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

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

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Staff were carrying out restrictive actions with people that was not in line with the assessed needs.

Right Care:
Care was not always person-centred and did not promote people's dignity, privacy and human rights. Safeguarding procedures were not followed and appropriate action had not been taken to protect people from abuse and poor care. Care was not always delivered in line with standards, guidance and the law.

Right Culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives.
The systems for reporting were not always open and transparent.
The provider's governance systems were not effective. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

Rating at last inspection
The last rating for this service was good (published 14 March 2019).

Why we inspected
The inspection was prompted in part due to concerns received about restrictive practices. A decision was made for us to inspect and examine those risks.

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.

You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Immediately following the inspection the provider has brought in internal senior managers from their wider organisation to undertake a full review of incidents including where necessary taking retrospective actions to safeguard people.

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

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people from abuse, person centred care, management of risks, safe premises and management and governance of the service.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

SENSE Tanglewood

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection team consisted of 1 inspector on the first day and 1 inspector and a senior specialist for the subsequent 3 days.
An Expert by Experience made calls to relatives for feedback on the service on 12 July 2023.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
SENSE Tanglewood is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. SENSE Tanglewood is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post, however they had been removed from the service by the provider on the 22 June 2023, and have since been deregistered.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 21 June 2023 and ended on 12 July 2023. We visited the location's service on 21,22,27 June and 6 July 2023.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and observed how other people were being supported. We spoke with 9 members of staff including senior operational staff, the registered manager and care staff. We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at 2 agency staff profiles and four staff files in relation to safe recruitment. We reviewed a variety of records relating to the management of the service, including policies, procedures and safeguarding incident records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse, Assessing risk, safety monitoring and management

● The provider had systems in place to safeguard people from the risk of abuse including the training of staff in how to recognise and report abuse, however the systems and processes were not applied effectively meaning people were at risk of avoidable harm.
● The registered managed had not taken action to investigate concerns staff raised regarding poor and abusive treatment of people using the service. For example, a whistle-blower had raised concerns to CQC regarding potential abuse regarding abuse to people in the service, this information was shared with the registered manager for them to investigate and take appropriate actions. When we inspected no action had been taken to mitigate the continuing risk of harm to people.
● One person's records showed they had been restrained by 2 members of senior staff during a care task. Their records showed the person had resisted but the use of physical force to complete the care task continued. This was not in line with their assessed needs and did not reflect an approach that considered least restrictive practices.
● Staff had told us concerns had been raised with the registered manager regarding potential safeguarding incidents, this was through the recording on incident forms, body maps and verbal reports from staff. There was no evidence these concerns were recognised, acted upon, or referred to the relevant authorities. This was not reflective of a zero-tolerance approach to abuse, unlawful discrimination, or restraint.

The provider had not taken action to protect people from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider brought in senior managers from within their wider organisation to undertake a full review of accidents, incidents and concerns. They also told us they would be consulting with staff to help identify any unaddressed issues and concerns.
● Relatives we spoke with told us they had not been aware of the potential risks to their loved ones until the inspection.

● The provider had failed to assess or to mitigate the risks to the health and safety of people who used the service.
● There was missing and inaccurate information regarding the management of people's health needs. For example, 3 people who had a diagnosis of epilepsy did not have any specific care plans, risks assessments or protocols related to their epilepsy. This meant it was not clear the actions staff needed to take in response

to any seizures people may have, although staff we spoke with said they would contact emergency services in the event of a person having a seizure.
● One person's care record did inform staff to await consciousness if the person had 'a major seizure'. There was no further information regarding this instruction, and it contained no date. This is not reflective of current medical guidance, for example the National Institute of Clinical Excellence (NICE) (Epilepsies in Children, Young People and Adults, NICE guideline, Published 27 April 2022).

Care and treatment was not provided in a safe way and risks to people's safety was not managed effectively. This is a breach of Regulation 12 (Safe care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection the provider had referred all people using the service to the learning disability services for full review of their health needs.

Using medicines safely,
● People's medicines were not managed safely.
● Medicines were not stored safely. For example, 1 medicines cabinet was located in a person's wet room meaning medicines were exposed to potential fluctuations of temperature, damp and affect the efficacy of the medicines. Temperature records between 7 June 2023 and 7 July 2023 showed temperatures went above the accepted range of 25 degrees Celsius on 6 occasions. No action had been taken to address this.
● A medicine cabinet containing prescribed medicines was on its side in a person's bathroom vanity unit. This meant medicines were accessible to people and were not stored in line with regulation.
● One person was prescribed medicine to be taken PRN (as required). The medicine had been opened. When we looked at this medication it had been open for 39 days when the instruction on the bottle stated do not use after 28 days. Using medicines outside of the manufacturer's guidelines meant the medicine may not function as intended. There was no system to ensure effective stock rotation of medicines, placing people at risk of not receiving effective treatment.

Medicines were not managed safely. This is a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider had taken steps to ensure medicine cabinets were fixed to the wall in suitable areas for the safe storage of medicines. They were also taking steps to contact the pharmacy for a review and advice on the existing medicines procedures in the service.

Learning lessons when things go wrong
● The provider had systems to learn lessons when things went wrong including oversight from senior managers. However, these systems had failed to identify the scale of inaction in responding to concerns and incidents.

Staffing and recruitment
● The provider's recruitment process included checks to ensure staff were of a suitable character. Staff files showed recruitment checks were robust, which included checks on staff through the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● We observed there were sufficient staff to provide people with the support they needed and what was reflected in their care records.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● There were no restrictions to visiting at the time of the inspection.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; Delivering care in line with standards, guidance and the law, Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Care and treatment was not always delivered in a way reflective of the principles of the Mental Capacity Act 2005 (MCA).
- There was no evidence in people's care records decisions made about care and treatment considered the involvement of people in their care. Decisions were made for them rather than with the people using the service. We could not find in people's care records where attempts had been made to adapt communication or to involve advocacy to ensure decisions were in accordance with the Mental Capacity Act 2005. For example, whilst there had been a best interest meeting regarding the use of restraint outside of their assessed needs to carry out an aspect of personal care. There was no evidence that any attempt had been made to engage or communicate with the person to gain their views or consent. During the restraint the records state they 'initial struggled', however the restraint continued. Staff did not recognise this as valid communication of not consenting to the intervention continuing.
- One person's care records documented an MCA assessment and best interest decision in relation to a specific decision to use a form of clothing as restraint to reduce the risk to the person. However, this process did not identify the decision was a form of mechanical restraint and therefore required a positive behaviour support plan (PBS) in line with the providers PBS policy and procedure (dated October 2022) to ensure appropriate use of restraint. This indicated that management and staff involved in the MCA and best interest

decision making process did not have the required level of competency to effectively implement training, legislation and national guidance about restrictive practices to protect the person's rights .

This was a breach of Regulation 11(Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Environmental risks associated with people's care and support had not been assessed or mitigated. This left people at risk of significant injury.

● One person had moved to another bedroom following a change in their mobility, however no mobility or moving risk assessments had been undertaken. This person had continued to have bruising and staff had shared concerns with the manager regarding the layout of furniture in the bedroom and concerns the person was banging into furniture when mobilising around their room. No action had been taken to look at ways to improve the layout of the bedroom. This meant actions had not been taken to identify and mitigate all risks related to mobility and falls.

● We found 1 person's room did not have any window restrictors even though windows gave access to outside public areas. Other window restrictors in the service were damaged and were not fitted in accordance with Health & Safety regulation, meaning they were not fit for purpose. This increased the risk of serious injury.

● We identified wardrobes were not secured to the walls in people's bedrooms. This could result in heavy furniture falling on people and left people at risk of significant injury.

● In the kitchen we found loose food products which were not decanted into sealed airtight labelled containers or dated as to when these products would expire. We also found sharp objects including knives that were not locked away, giving access to people that used the service and increasing the risk of significant injury.

●Staff told us one person's bedroom door did not lock. We found it was not locked and gave access to an area not secure from the public, meaning the public could have accessed the person's bedroom directly from the street.

The provider had not ensured the premises and environment was safe or secure. This was a breach of Regulation 15 (Premises and Equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider had taken steps to ensure doors were locked and new locks had been fitted to the gates meaning there was no longer direct access for members of the public. The provider had taken steps to ensure all wardrobes were secured to the wall and arranged for all window restrictors to be replaced by an external contractor. The provider had also ensured sharp objects were safely stored and food items were suitably labelled and stored.

Supporting people to eat and drink enough to maintain a balanced diet, Staff working with other agencies to provide consistent, effective, timely care

● The management of people's nutritional and hydration needs were not always effective.

● One person had part of their eating and drinking guidelines displayed on the inside of a kitchen cabinet. The guidelines were dated 2016 and were page 3 of 3, pages 1 and 2 were not in the persons records and staff could not tell us what information was missing. Whilst the information told staff the food texture was 'soft and moist', there was no information about what the person's needs were in relation to the thickness of drinks. There was no evidence of input from Speech and Language therapy in the writing of the guidelines and no risk assessment in relation to choking, it was not clear what the choking risks were for this person.

● Another person's 'Eating and Drinking Guidelines' (dated 16 June 2015) stated they were known to eat at a very fast pace and regurgitate food during mealtimes. There was no information or assessment of the likelihood or severity of the risk of choking. We observed staff supporting this person verbally prompt them to slow down when eating their lunch. This issue was not reflected in the screening tool completed by the registered manager 28 March 2023. This inaccuracy meant monitoring was ineffective in identifying and escalating risk.
● Staff told us they had raised concerns with the management team previously about the lack of clear guidance around people's eating and drinking needs in care records but told us nothing had been done to improve the situation.
● Whilst the provider had developed their own 'Managers' Eating and Drinking Screen'. This screening tool did not reflect current best practice and national guidance or provide clear guidance about what managers should do when people's needs changed. One person's care records stated certain changes in risk should be referred to a Speech and Language Therapist, however other guidance on the screening tool stated a referral was not required in these circumstances. This was confusing and potentially the person at risk of harm if referrals were not made in a timely manner.
● We found a screening tool completed by the registered manager 28 March 2023 for 1 person using the service indicated 2 areas of concerns but there was no information about whether this was a change in their needs or what actions were being taken to mitigate any risk.

The provider had not ensured the safe management of people's nutritional and hydration needs. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff supporting people to eat and drink were patient and were aware some people's food needed to be modified. One member of staff said, "[Person's name] food is softened, they won't have tough meat or rice. We put meat in a food chopper and keep it on the wet side and chopped quite small."
● Relatives told us they felt people had choice and a range of food and drinks and had not experienced any concerns regarding eating and drinking.
● Immediately following the inspection, the provider was contacting the local learning disability team for support on re assessing people's needs.

Staff support: induction, training, skills and experience
● Staff did not feel supported by the management team. We raised this with the provider and they had started to engage with staff and identify the support that staff needed in their roles.
● New staff completed induction training prior to commencing working in the service.
● Staff told us there was regular training updates including training in learning disabilities and autism.
● The provider had systems to track staff training and identify when refresher training was required.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- There was no evidence of involvement of the person in key decisions about their care. For example, where decisions had been made to use restraint to complete a care task although there had been a best interests meeting, this did not involve the person themselves and there was no demonstration that attempts had been made to consider the individuals views.
- Where concerns had been raised or incidents occurred, there was no evidence that attempts had been made to gather the views and experiences of the individual.

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

- We observed staff were patient and created a warm and inclusive atmosphere. People appeared to be at ease and responded positively to staff engagement with smiles and laughter.
- One person indicated to us by a thumbs up they were happy with how staff cared for them. One relative said, "They (staff) are caring whenever I've been there."
- Staff had knowledge of and had training in equality and diversity and we saw staff treated people with dignity and respect.
- Where people indicated they wanted time in their rooms, staff ensured their choices were respected.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- The care and treatment people received was not always reflective of their needs and did not always reflect a person centred approach.
- During the inspection visit, 1 person was heard telling staff 'tummy ache' as they were about to have their lunch. When we asked staff about this, they told us they believed this was a behaviour. However, when we looked at the care records there was no evidence of any consideration of referring to health professionals to identify any potential causes. There was no action taken to ensure their needs continued to be met.
- One person's care records stated 'clinical assessment to check the health of the eye should continue.' However, there was no evidence in what staff told us or what the care records showed to indicate that the person had seen an optician. One person had a diagnosis of irritable bowel syndrome, however there was no evidence of input from health professionals (for example a dietician) and there were no care plans on how to manage this.
- People's care records did not show where or how people were involved in planning their care. Decisions were made for rather than with the people using the service. We could not find in people's care records where attempts had been made to adapt communication or to involve advocacy to ensure decisions made involved the person themselves.
- There were no clear goals or aspirations recorded in people's care records.

The provider had not ensured people's care was person-centred. This was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's experiences did not consistently reflect an approach promoting their preferences, aims, wishes, or goals. Whilst there were times when people were out or engaged in activities such as art and craft activities, we found activity was sporadic and did not reflect what had been recorded in people's care records regarding their preferences and interests.
- Staff told us there was a lack of drivers and also of direction and planning in what they were able to do on a shift to shift basis.
- One relative spoke of their family member doing baking and cooking, but also expressed that they did not get out as often as they used to and was aware of a lack of drivers in the service.

Improving care quality in response to complaints or concerns

- The provider's systems had not identified or responded to concerns raised by staff. There was no system

to support people raising any concerns or complaints they may have about the service.
● There was a system for complaints, however the relatives we spoke with told us that they had not made any complaints.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● There were assessments of people's communication needs in their care records. We saw that staff took time to understand what people were communicating. However not all communication tools were maximised, for example 1 person's care plans stated they had a communication box which contained objects of reference. We found this was not available to the person to support them to make choices.
● Staff were observed to engage with another person using their individual communication systems such as Makaton, which is a unique language programme that uses symbols, signs and speech to enable people to communicate and a communication box which contained objects of reference, to involve the person in choices and prepare for activities.

End of life care and support
● There was information in people's care records about end of life wishes.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Working in partnership with others

- Auditing systems and checklists in place were not effective in keeping people safe.
- The provider's systems had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Where risks were identified, measures to mitigate the risks had not been implemented.
- Systems and processes failed to identify inappropriate use of restraint, staff had not followed approaches in line with least restrictive practice.
- The provider's systems and processes were ineffective and failed to identify concerns found on this inspection. This included a failing to mitigate and monitor risks to the health, safety and welfare of service users and others.
- The culture of the service did not meet national policy or best practice for supporting people with a learning disability. Care and support did not promote an approach that empowered and included people in their own care.
- Systems were not in place to ensure safeguarding incidents were consistently shared with the local authority to allow investigation of people's safety. The lack of reporting to relevant agencies led to a lack of external oversight and promoted a closed culture.

There was no effective management or governance of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Although the provider had systems to identify when safeguarding incidents were investigated and escalated to other agencies where necessary, they had not been effective in ensuring safeguarding incidents were consistently shared with the local authority to allow investigation of people's safety. The lack of reporting to relevant agencies led to a lack of external oversight and promoted a closed culture. External scrutiny was actively discouraged, and poor and abusive care allowed to continue unchecked.

There had been a failure to act in a way that was open and transparent. This was a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider did not encourage people to be involved in the development of the service.

Continuous learning and improving care

● The lack of governance and oversight by the provider and management team did not promote change, improvement or learning from when things went wrong.

● During the inspection the provider had taken steps to bring in senior managers from within the wider SENSE organisation to review incidents, concerns and to engage with the staff. Where required retrospective safeguarding referrals had been made and other agencies including the police were informed of the more serious concerns.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured the safe management of people's nutritional and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises and environment was safe or secure.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour There had been a failure to act in a way that was open and transparent.

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 The provider had not ensured that care was person-centred.

The enforcement action we took:

Serve a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided in line with the principles of the Mental Capacity Act (2005).

The enforcement action we took:

Serve a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way and risks to people's safety was not managed effectively.

The enforcement action we took:

Serve a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken action to protect people from abuse and improper treatment.

The enforcement action we took:

Serve a Warning Notice

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no effective management or governance of the service.

The enforcement action we took:

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