Sutton Court Associates Limited

Baytree House

Inspection report

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Date of inspection visit:
30 September 2021

Date of publication:
17 January 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Baytree House is a residential care home for people living with a learning disability and autistic people. It is registered to provide personal care for up to 9 people; at the time of inspection 9 people were living at 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 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 or autistic people.

People's experience of using this service and what we found
People were not safe from abuse. The provider had failed to ensure safeguarding systems were robust and had not ensured managers and staff had suitable training, skills and knowledge to report incidents of potential abuse. Lessons had not been learnt from a recent inspection of another of the providers locations.

Risks to people had not been fully considered and did not encourage positive risk taking. Managers and staff lacked suitable training and skills to always support people whose behaviours may challenge themselves or others safely in the least restrictive and most person-centred way. The provider had not fully considered safety risks in the service or the potential impact these could have on people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. The model of care and setting did not maximise people's choice, control and independence. The layout of the premises offered limited space. The dining area was also used by managers to work on their laptops as the office was on the top floor and so cut off managers from being able to observe and interact with people and staff.

People were supported by staff who knew them well, however the provider had failed to ensure staff had received suitable induction or training. This meant people did not always receive person-centred care or support which promoted people's dignity, privacy and human rights. Care and activities did not focus on developing people's strengths and aspirations.

People were not supported by managers and staff who understood current best practice in relation to learning disability and/or autism. The provider had failed to ensure managers and staff received support to keep their knowledge and skills up to date. There were shortfalls in governance systems which did not ensure people remained safe, lessons had been learnt or improvements made.

Some people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and

systems in the service were not always understood by managers and staff.

People were positive about their experience of the service. Some had lived at Baytree House for many years and one person told us, "It's nice here." They went on to describe other people who lived at Baytree House as "Their friends". Some people were unable to express their views. Relatives were positive and told us, "It's absolutely fantastic" another said, "I'm very impressed."

People told us they liked the garden and enjoyed the meals. People were happy to show us their rooms which were personalised and reflected their choices. People told us about activities they were participating in which included regular walks, shopping and art and craft activities in Baytree House.

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 good (published 27 September 2019). The service has now been rated inadequate.

Why we inspected
This inspection was prompted in part due to concerns about people's safety we identified in another of the providers locations. We inspected in order to provide assurance people were safe and to check the service was applying the principles of Right support, right care, right culture.

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 have found evidence the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

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

Following the inspection the provider has taken some actions to mitigate the risks. This is an ongoing process.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, safe care and treatment, safeguarding, staffing, notifying CQC of incidents and governance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

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.

Baytree 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
Baytree 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager covers some other services for the provider and Baytree house also has a home manager who works exclusively at the service, providing day to day management.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and two relatives about their experience of the care provided. We spoke with five members of staff including the registered manager, the home manager and care workers.
We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted two professionals who regularly visit the service.

Inadequate

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 good. At this inspection this key question has now deteriorated 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; Learning lessons when things go wrong

- People were not safe from abuse. Systems and processes to protect people from the risk of abuse were not operating effectively.
- For example, within a five-week period, four incidents recorded one person slapping another person and the registered manager failed to report all these incidents to the local authority safeguarding team.
- The provider could not be assured incidents were always identified, reported or managed in line with current good practice guidance. Right support, right care, right culture guidance requires providers to ensure autistic people and people with a learning disability receive care which promotes and respects people's human rights.
- Records evidenced actions staff took in response to managing some incidents. These included potential restrictive interventions including segregation and seclusion. The practice of encouraging people to go to their rooms when they became emotional distressed could lead people to feel unable to express themselves and there were no strategies were in place to help people to express their feelings in a more positive way or to identify and address the causes of the distress felt by people. This placed people at risk of repeated harm to themselves and/or others. Similar concerns had been identified during a recent inspection of another of the providers locations.
- The provider had not ensured lessons had been learnt. Not all staff had received training in safeguarding or training to ensure their understanding of potentially restrictive practices.
- Management practice failed to demonstrate their responsibilities for identifying and reporting concerns. Actions to reduce the risk of this happening again had not been taken allowing the incidents to continue.

The provider did not ensure that safeguarding systems and processes operated effectively to prevent abuse. The provider failed to ensure incidents were reported in accordance with statutory obligations in a timely manner as a result this placed people at ongoing risk of abuse. This is a breach of Regulation 13 Safeguarding service users from abuse and improper treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reported these incidents to the local authority for consideration by the safeguarding team and informed the registered manager. The registered manager acknowledged these concerns and told us actions they planned to take including a review of incident management and safeguarding systems to ensure they were effective. They told us, "We will review our policy to ensure it complies with regulatory responsibilities". They also provided assurance they had scheduled appropriate training for staff to ensure the management of incidents improved.

Assessing risk, safety monitoring and management

● Risks to people were not always assessed or monitored.
● Risk assessments were not always in place and did not always contain adequate information to provide staff with information to mitigate health risks. For example, during the inspection we observed a person coughing during a meal, staff intervened and made the person safe by employing first aid measures. We spoke with staff and the home manager following this incident. They told us this was something they had noticed increasing for this person over the past few months. A staff member said this happened, "Sometimes when eating and drinking but also when person was cleaning teeth, it's quite worrying". The significant risks related to aspiration or choking had not been considered, no risk assessments were in place and staff had not received training or guidance in order to identify the importance of seeking specific health advice from medical practitioners.
● The manager acted immediately to contact health professionals including Speech and Language Therapy (SALT) to ensure the person received appropriate support to assess this risk, ensure effective support was in place to manage this risk and provide staff with guidance to support this person safely.
● Autistic people did not have assessments of their sensory needs. This meant potential adaptions to the environment had not been considered and adapted to meet people's sensory needs and reduce any negative impacts on people from the environment.
● People's care and support was not provided in a safe and well-maintained environment. Incident reports noted a person had red marks on their back from standing for long periods of time against a hot uncovered radiator. This was a known practice for the person but had not been considered a risk and no action had been taken to protect the person. Following the incident, the provider did have this radiator enclosed however, other radiators in the building remain uncovered and had not been risk assessed.
● A stair lift was fitted, and one person was reported to use it. Risks posed to the person using it or what support they would need had not been considered and recorded to guide staff. The stair lift also presented as an obstacle to others walking on the stairs, again these risks or support needed had not been considered or recorded.
● Risks to people from fire had not always been assessed effectively. A fire evacuation plan to be carried out in the event of an emergency at night included a single staff member supporting people to a minibus in the car park then returning to support others to evacuate the service. This had not been tested to ensure this was effective or practicable. The provider could not be assured people and staff could evacuate the building safely. Our concerns were communicated to the fire safety service. We informed the registered manager and they provided assurance they would complete a review of this process to ensure it was effective.

The failure to assess, record and mitigate risks to people's health and safety was a breach of regulation. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment)

Using medicines safely
● People did not always receive their medicines safely or in accordance with the prescriber's instructions. 'As required' medicine (PRN) did not always have a protocol in place to guide staff describing what the medicine was prescribed for or details such as dose instructions, signs or symptoms about when to offer the medicine, interventions to use before medicines offered.
● One person was prescribed a PRN medicine to be offered up to four times per day for pain. Medicine administration records (MAR) noted this had been consistently administered three times each day as a prescribed regular medicine.
● Medicine management systems had not identified this had been prescribed as a PRN medicine and staff had not sought clarification from the prescriber to ensure this medicine had been managed safely.
● Medicines were not always administered in line with good practice guidance. For example, The medicine cabinet and medication administration record (MAR) were located on the top floor of the building and

medicine was dispensed there but given to people on other floors in the building without the MAR record available to check information was correct and if the person required any further medicines. The staff member completed the record after the person had received the medicine away from the person.
● Medicine audits were not effective or robust. These consisted of a weekly stock check of medicines. They had not identified concerns with PRN medicines or considered risks with the medicines processes operating in the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following inspection, the registered manager provided assurance they would review medicines management to ensure this was safe.

● People's medicines were regularly reviewed with health professionals. For one person this meant they were supported to safely reduce and stop a medicine used to manage distress and anxiety.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Toilet facilities shared by people, staff and visitors did not have handwashing facilities as a result people used handwashing facilities in a bathroom next door. We spoke with the registered manager and the home manager about the cross-infection risk this practice presented. The registered manager provided assurances they would review this practice. We were assured staff were completing regular cleaning of high touch areas reducing the risk.
● We were not assured that the provider was always using PPE effectively and safely. Staff were not always wearing masks consistently. Several staff were observed wearing masks below the nose.

The registered manager was not doing all that was reasonably practicable to ensure infection prevention control was managed in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment)

We spoke to the registered manager to ensure this practice improved and was in line with current guidance

● We were assured that the provider was preventing visitors from catching and spreading infections. A relative confirmed to us they took a lateral flow device test and waited for a negative result before being allowed into the home.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was meeting shielding and social distancing rules and accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed and the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● Staff were recruited safely and in line with best practice. Records showed applications forms were completed and included employment histories. Suitable checks such as references and Disclosure and Barring Service (police checks) were obtained prior to employment

● There were sufficient staff to meet people's needs. We observed staff were prompt in supporting people who needed assistance. People told us staff were kind to them and how they always had time to chat; we saw this in practice.

● Through the inspection we observed staff interacting with people. People were relaxed with staff and spoke positively about the service and the staff.

● One person said, "I like it here, it's nice" another person said, "I can call for help and staff come".

● We asked staff about staffing levels. One staff member said, "We have had some staffing problems. New staff have joined, and we are covered quite well it would be nice to be fully staffed again."

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience; Assessing people's needs and choices, delivering care in line with standards, guidance and the law

- People were supported by staff who had not received consistent guidance or training to support people with a learning disability and autistic people. Training records showed most staff had not received recent training in these areas.
- CQC would expect providers of services for people with a learning disability and autistic people to demonstrate how they are complying with the principles of right support, right care, right culture guidance. People were not supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This increased the potential of people not receiving empowering care tailored to their needs
- Staff we spoke with recognised what might trigger episodes of emotional distress for a person and described this, "I've got to know (person) and their triggers, I try to remove them to a safe place, to their room, or distract them." Records confirmed, staff had followed this practice, which reacted to a person becoming distressed but did not consider any action to support the person to avoid or remove known distressing situations in the first place.
- The registered manager told us they, "Preferred face to face training". This had been a challenge during the COVID-19 pandemic. However, it was not evident from speaking with staff what action had been taken to ensure staff were provided with training to support people with a learning disability and autistic people. This meant the provider and registered manager could not be assured staff had the skills and knowledge to work effectively to meet people's specific needs.
- Staff induction was informal and relied on information provided by managers and staff. CQC would expect the provider to support new staff to complete The Care Certificate or an equivalent. This would provide the new staff member with some skills and understanding of key areas to support people effectively. These skills are built upon with experience and training specific to the people they support and their role within the service. Staff we spoke with had not been offered the opportunity to complete this or had been informed it was available. Records confirmed staff had not received this.
- The provider could not be assured new staff were receiving consistent induction or that they were shadowing good staff practice, and this increased the risk of people not receiving support in line with current best practice.
- Not all staff had received training for people's communication needs. For example, staff had not been trained in Makaton, a communication aid used by some people in the service. During the inspection one person communicated using Makaton signs. Staff were not observed responding to them using signs or acknowledging the person's use of these signs. Care plans either did not include information about signs

and gestures people used to express themselves or guidance for staff in how to respond to people when they used signs.

The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's needs and choices had not been holistically assessed
● People did not have individualised care in line with their preferences and assessed needs. People did not have communication or sensory assessments. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care. The provider had not considered how this impacted on people who might be experiencing emotional distress and the affect this may have on others living in the service.
● Managers had not fully considered people's strengths or focused on what they could do, so that people had a fulfilling and meaningful everyday life. For example, one person regularly went the same walks with staff. Staff had consistently noted their interest in a particular animal. It was not evident from records this person had been supported to develop this interest beyond observations. There was no consideration of how this interest could be promoted and as a result the person had not been supported to develop strengths in this interest.
● People did not always have opportunities to develop strengths and skills. The small size of the kitchen and the number of people who could potentially prepare their own food with staff support were incompatible. This meant that people did not get the opportunities to fully develop and practice skills.
● People's records did not include details of pro-active strategies for staff to deploy to reduce the occurrence of triggers which could reduce the need for staff to support people following incidents.
● The provider had failed to ensure assessments had been completed and this resulted in a lack of guidance for staff in how to support people when they are distressed and presenting with behaviours which may challenge others.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the registered manager provided assurance staff had been scheduled to "Complete Positive Behaviour Support (PBS) training" and some had already taken place. They went on to say, "This has raised many questions for us and we will need to review everything we are doing." The registered manager explained that they needed to carry out quality of life assessments for everyone as it was clear that people were not getting opportunities to have enriching and meaningful experiences.

● Staff had regular supervision and consistently told us they felt supported by the managers. One said, "best job I've had, I feel supported and valued. My line manager has dealt with things quickly." Another said, "The managers are there for support if I'm not comfortable they're more than happy to share or show me."

Supporting people to eat and drink enough to maintain a balanced diet
● Some people were supported to make their own drinks. People were offered a choice of drinks regularly.
● Staff mainly prepared and cooked most meals. Shopping was ordered by staff using the menu agreed with people. The home manager explained, "The menu is chosen once a week, people get to choose one meal a week which is their favourite."
● Staff took account of people's dietary requirements and ensured people were offered choices in line with

those needs. For example, one person with a food intolerance was supported to have choices by deciding from a catalogue of meals.
● People told us they enjoyed the meals and had plenty to eat. One person said," I like the food, I like shepherd's pie and lasagne."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care.
● People were supported to access the health care services they needed.
● A relative told us they had confidence that staff recognised changes in people's health. They explained, "There are comprehensive files and medical notes I'm very lucky I haven't had to worry about a thing. Things are monitored and we are involved in medical discussions."
● Another told us how the health of their loved one had improved, "During lockdown (person) was well looked after, they've lost weight, are more occupied and happier."
●Hospital care passports were in place and contained up to date information on people's health status. This meant that hospital staff would have the information they needed if someone was admitted to hospital.
● A health professional who regularly visited the service told us, "Often I have given (health) advice to staff/management and this has always been followed through." This provided assurance people were receiving consistent support with specific healthcare needs.

Adapting service, design, decoration to meet people's needs
● People were supported to personalise their rooms this included choices about the decoration.
● There had been some adaptations to the building for example a stair lift had been installed to support people with mobility needs. People's rooms had window restrictors to ensure they remained safe.
● People appeared relaxed in the service and spent time in communal areas and their rooms. One person told us how much they enjoyed time in the garden.

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 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

● Staff spoken with understood the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards. However, staff were not consistently applying the principles when supporting people to make everyday decisions. For example, records relating to incidents had recorded staff not always supporting people in the least restrictive manner. We have reported on this within the safe section of this report.

● People had received mental capacity assessments and these included details of the help people might need to make decisions. There was clear information about the processes to follow to ensure where people

lacked the capacity to make decisions these were made with them and in their best interests.

● People had an authorised DoLS and the registered manager had a system to follow up with the local authority when it was due to expire. Records showed, where a person had conditions these were being met. For one person, this included a medicine to be kept under review and records confirmed this was being met and had resulted in a reduction of medicines.

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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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There were significant shortfalls in the management and oversight of people's care and support. This inspection was prompted in part due to concerns identified at a recent inspection of another of the providers locations. The provider had not ensured lessons learnt from that inspection had been shared with Baytree House and similar themes have been identified.
- The provider had failed to ensure managers and staff recognised and reported allegations of abuse or restrictive practices. Training had not been followed up to check staff had gained the knowledge and competency required.
- The providers safeguarding policy was not robust and did not provide staff with guidance to ensure all allegations of abuse were reported to the local authority or to CQC. This had happened on four occasions in the two months prior to the inspection.
- The provider did not have adequate auditing processes in place to ensure they were continually monitoring the risks to the health, safety and welfare of people. For example, management reviews of incidents had not identified people being subject to unauthorised restrictive practices and failed to ensure staff received appropriate support and training. The registered manager spoke about audits and told us, "Auditing is not evidenced we need a system."
- Leaders did not demonstrate they had the knowledge and skills to identify people were not receiving support in line with current good practice guidance and this shortfall resulted in incidents of harm continuing. For example, people continued to be subject to restrictive practices and staff had not received training which included alternative strategies they could deploy to support people when distressed. It was not evident the registered manager had effectively mitigated the risks to people and staff.
- The provider had failed to keep the culture of the service under review and ensure people were supported in line with the principles of right support, right care, right culture. They could not be assured people were supported in a person-centred service where the culture had a focus on continuous learning and improvement.
- The provider did not have effective systems to monitor the environment and as a result risks to people. For example, they had not identified concerns with the need to test fire arrangements at night to ensure the plan was safe and effective. Another example, systems had not identified the risk un-protected radiators presented to people living in the service or taken action to mitigate potential risks to other people.
- Infection Prevention and Control audit systems were not effective or robust. The provider had not acted to ensure hand washing facilities were managed effectively or that staff were wearing masks correctly was

monitored to ensure people remained as safe as possible.
● Medicine management systems had not identified the lack of information about PRN medicines or reviewed the medicine system and as a result failed to identify the potential for medicine errors to occur.
● The provider did not have quality monitoring systems in place to monitor staff practice and competency or identify the need for training in specific health conditions. This shortfall increased the risk people did not receive effective support with their needs which respected their human rights or was in line with current good practice guidance.

The provider had failed to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager responded during and after inspection and told us, "They planned to put together an action plan to ensure they picked up on the points raised at inspection."

●The provider had failed to notify us of specific events that they are statutory required to do so. This was a breach of regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009

We spoke to the registered manager who provided assurance they planned to take immediate action to address this.

● People appeared relaxed in the presence of the home manager and the registered manager. From observations on the day, it was clear the managers knew people well and took the time to engage them in activities and conversations.
● Relatives were consistently positive about the home manager and how they managed issues. One said, "Their attention to detail is really strong and I'm very impressed with them". Another said," I'm confident they would deal with any concerns if I needed to raise them".
● Staff described the managers of the service as being," Open" and being able to "Approach any of the managers if I needed to."

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
● The provider did not always act on the duty of candour. We have reported on this within the safe and well led section of this report.
● Relatives were confident the home manager and staff would ensure they would be made aware if something went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People were involved in the service. Staff completed regular house meetings with people where activities and ideas were discussed.
● Relatives told us how the home manager had kept them involved and informed through the COVID-19 pandemic. One said, "Communication is really good". Another said, "The (home) manager is the tops, during the lockdown they organised Skype calls. Nothing was too much trouble; all the staff have been brilliant."

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 failed to ensure care and support was appropriate to meet people's need

The enforcement action we took:

positive conditions on providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure safe care and treatment. (proper and safe management of medicines and assessing risks to health and safety)

The enforcement action we took:

positive conditions on providers registration

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 failed to ensure people were safe from abuse and improper treatment.

The enforcement action we took:

positive conditions on providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people were at risk of receiving poor quality care.

The enforcement action we took:

positive conditions on providers registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs

The enforcement action we took:

positive conditions on providers registration