Achieve Together Limited

Arundel House - Frinton-on-Sea

Inspection report

34 Harold Road
Frinton-on-sea
CO13 9BE

Tel: 01255852046

Date of inspection visit:
26 January 2023
31 January 2023

Date of publication:
27 March 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Arundel House – Frinton-on-Sea is a residential care home providing personal care for up to 10 people who have a learning disability and/or autistic people. People living at the service may also have a mental health condition. At the time of the inspection there were 10 people living at the service.

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:
The provider failed to ensure enough staff were deployed to meet people's needs. People were not supported to be independent and have control over their own lives. There was limited evidence recorded of meaningful activities being undertaken and activity plans had not been developed. Whilst staff were familiar and understood people's individual needs, staff were task focused and people were not supported to achieve their goals and aspirations. Community activities were not being provided and people were not supported to take part in household duties and meal preparation.

There were a range of policies and procedures in place; however, these were not being implemented at the service effectively.

There were elements of the environment in need of updating. Risks posed by the environment had not been identified and as a result had not been resolved. Where risks had been identified insufficient action had been taken to mitigate these risks. Infection prevention and control measures were not robust and some areas of the service were visibly dirty and unhygienic.

Right Care:
The provider failed to verify systems and processes were operated effectively, to ensure incidents of suspected abuse were reported to the appropriate authority. Staff were kind, compassionate and attentive yet they failed to identify poor care and suspected abuse.

We found medicines were not always safely managed and medicine records were not always completed accurately.

There were identified gaps in staff training and we were not assured staff had the skill and knowledge to fill the requirement of their role.

Care records required a review to ensure they reflected people's current needs. Peoples individual risk assessments were either in need of updating, were incomplete or missing.

Right Culture:
The providers governance systems in place had failed to identify issues and drive necessary improvements to the quality and safety of the service. Managers did not always identify problems or concerns and therefore they missed opportunities to improve the safety of care and treatment people received.

Staff had not received training or information in relation to best practice and the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. There was a culture of doing 'for' rather than 'with' 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 under the previous provider was good, published on 8 June 2017.
This service was registered with us on 10 October 2020 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Arundel House – Frinton-on-Sea on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, safeguarding, staffing, person-centred care and good governance at this inspection.

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

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

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

Special Measures:
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. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Arundel House - Frinton-on-Sea

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 2 inspectors and an Expert by Experience.
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
Arundel House – Frinton-on-Sea 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. Arundel House – Frinton-on-Sea 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 not a registered manager in post. A new manager had been in post for 14 months who intends to submit an application to register.

Notice of inspection
This inspection was unannounced. Inspection activity started on 26 January 2023 and ended on 14 February 2023. We visited the location's office/service on 26 and 31 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last 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 observed the care provided to help us understand the experience of all people, in particular those who could not talk with us. We spoke to 7 staff members including the manager. We reviewed a range of records, including 5 people's care records. We looked at 3 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.

Following the inspection we spoke to 6 relatives. We continued to seek clarification from the provider to validate evidence found. We looked at training and quality assurance 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, under the previous provider, 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.

Assessing risk, safety monitoring and management;

- We found risks to people were either not assessed or were conflicting and their safety was not monitored.
- People's care records and risk assessments were not always updated to provide staff with the information they needed to ensure people were safe and cared for appropriately. For example; 1 persons managing behaviour plan refers to their previous home and is dated March 2013.
- The management of risk plan within each person's care notes used a standard template and were generically written. All proposed actions to eliminate risk were standard to every risk. These did not assess the immediate and actual risk on an individual basis.
- Where risk had been identified, no information or guidance to a specific concern had been provided. For example, 1 person had an identified risk of when in a distressed state can make allegations against other people. No detailed, information or procedure to follow had been provided should an allegation occur, to keep them and others safe.

The provider had failed to assess the risks to health and safety of service users and do all that is practicable to mitigate any such risk. This was a breach of regulation 12(2)(a), (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had detailed Personal Emergency Evacuation Plans [PEEPs] in place, which were regularly reviewed and updated. Evacuation procedures had been practiced to ensure people could be evacuated safely in the event of a fire.

Using medicines safely

- People's medicines were not managed and administered safely which placed people at risk of harm.
- Staff did not record where a medicine patch had been applied and therefore there was no assurance that the patch was rotated correctly. This increased the risk of the person encountering side effects.
- 1 person's when required [PRN] medicine, had been split in half by hand and stored in a separate pot. The medicine in the pot showed the tablets were not equally split. This demonstrated that people did not always received their medicines as prescribed, placing people at risk of harm.
- We found stock records for a person's PRN was not accurate compared with physical stock held. There was no information about whether any action had been taken to investigate the discrepancy.
- We found stock records for another person's PRN had not been recorded on their Medicine Administration Record [MAR] form. There was no information about whether any action had been taken to investigate the discrepancy. This meant we could not be sure medicines had been administered safely.
- The medicines audit was not robust enough to identify the concerns noted on inspection.

The provider had failed to ensure risks related to medicines were appropriately managed. This was a breach of Regulation 12(2)(f), (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Adequate systems were not in place to prevent and control the spread of infection. We found the premises to be unclean and/or unhygienic. Service user's ensuite facilities; bathroom and shower room equipment; personal mobility aids and communal toilets were dirty.
● We found the environment to be poorly maintained and standards of hygiene in some areas were inadequate. Failure to ensure the environment is clean, hygienic and safe, puts people at risk of harm and infections.
● The providers infection control policy was updated and in accordance with government guidance. However, there were no enhanced or more frequent cleaning schedules in place at the service to minimise the risk of spreading infection. Failure to maintain robust infection control practice puts people at risk of harm.
● The infection, prevention and control audit was not robust enough to identify the concerns noted on inspection.

The provider had failed to adequately manage the control and spread of infection within the service. This was a breach of regulation 12(2)(h), (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● We were not assured, systems and processes in place safeguarded people from the risk of abuse.
● During the inspection, we identified 1 person who had multiple events of unexplained bruising. These had not been escalated and explored by the manager to determine whether there was a safeguarding concern.
● An accident and incident record detailing an allegation of abuse against a staff member had not been escalated. This indicated a lack of awareness regarding the reporting of potential abuse to others, such as the local authority and to the Care Quality Commission.
● An accident and incident record detailed an incident of choking of a person living at the service. The manager had not recognised this as a safeguarding incident and therefore did not make a required referral to the local authority.
● During the inspection, we observed one person being shouted at by other people living at the service on a regular basis. The manager and support staff had not recognised this as a sign of abuse and safeguarding concern and therefore did not make a required referral to the local authority, in line with the providers own policy.
● Where accidents and incidents had been recorded, there was no evidence this information had been analysed for themes and trends, or to identify any learning opportunities to minimise the risk of future reoccurrence.
● We shared our concerns with the local authority and at the time of this report, safeguarding investigations were still taking place.

The provider had failed to implement robust procedures to protect people from abuse. 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.

● One relative told us, "Yes, we do, we feel [name] is very safe there. We are happy with their care." Whilst another told us, "When I go to visit, they seem OK but I don't live there, so I don't know what they're like."

Staffing and recruitment

● We were not assured there were sufficient staff to meet the needs of the people living at the service.

● During the inspection, the manager provided us with information about people's dependency needs in order to determine the required staffing levels. This did not consider or include when staff were deployed to complete additional tasks such as the cleaning schedule and/or kitchen duties.

● The dependency tool calculated 5 staff members were required for the morning shift. The core hours noted 1 staff member to 3 people living at the service. However, during the first morning of our inspection, 2 staff members were deployed to clean the service and 2 staff members supported 1 person to access the community. This left 1 staff member to support 9 people living at the service.

● The dependency tool calculated 4 staff members were required for the afternoon shift. The core hours noted 1 staff member to 3 people living at the service. However, during the afternoon shift 2 staff members supported 1 person to attend a scheduled medical appointment. This left 2 staff members to support 9 people living at the service.

● During the same afternoon people did not received their evening meal at the scheduled time and were becoming very restless as a result of waiting. We asked staff members why the evening meal was late and they told us it was because there wasn't enough staff to cook.

● The manager told us of the staffing levels they were commissioned for. This included where people were in receipt of 1 to 1 and/or 2 to 1 staff support. The manager was unable to provide evidence of how or if the time was being utilised.

● Staff members told us the service did not have enough staff to support 1 to 1 and/or 2 to 1 activities. The manager was unable to evidence how dependency levels were considered in determining staffing levels and their deployment at the service.

There were insufficient numbers of staff to adequately meet people's needs. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had processes in place to recruit staff safely. Applicants' references were checked and verified in line with best practice and gaps in employment were explained.

● Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes

People's relatives were supported to visit the service. Relatives confirmed there were no restrictions to visiting and that government guidance was being followed.

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 our last inspection, under the previous provider, we rated this key question good. At this inspection the rating has changed 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

- During the inspection, we reviewed the staff training matrix and found the service only had a compliance of 45% of face to face training completed. The manager had told us face to face training had not recommenced since Covid-19, though it was planned to restart in 2023. This meant, the support staff had not received practical training in moving and handling, including the use of equipment.
- Not all support staff were up to date with the providers mandatory eLearning which included, infection control; safeguarding; fire awareness; moving and handling and supporting people if choking training.
- There had been a choking incident of a person living at the service and although this was managed well, without training, we were not assured that staff had the skills necessary to support individuals at risk of choking.
- One staff member had not completed or was up to date with any of the mandatory eLearning.

The provider had failed to ensure staff had received adequate training to fulfil the requirement of their role, placing people at risk of harm. This was a breach of regulation 18(2)(a), (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- New staff had undertaken an induction process where they shadowed experienced senior support workers.
- 12 out of 14 support staff had completed The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been assessed. However, care plans were not up to date, or particularly individualised or reflective of the person's voice. They did not reflect a good understanding of people's current needs, including relevant assessments of people's communication support and sensory needs.
- Goals and longer-term aspirations had been identified for people. However, there were no clear pathways to support people to achieve those goals. There was no record of discussions or a review to see what had or had not worked.

The provider had failed to ensure people received appropriate care and treatment that reflected their personal needs and wants. This was a breach of regulation 9 (Person centred care) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Not all areas of the service had been well maintained. Paintwork around window frames, on skirting boards and walls were scuffed and/or peeling and in some area's windowsill paint was chipped exposing the wood beneath. 1 person's room had a significant hump in the flooring which increased the risk of falls.
● The interior and decoration of the service was not adapted in line with good practice to meet people's sensory needs.
● The activity area, leading off the main communal lounge and dining room, overlooked a nicely landscaped garden which people could access and use safely. However, a summer house previously used as a sensory room, was now used as a storage shed.
● Access to the building was suitable for people with reduced mobility and wheelchairs. Access to the upper floor was by a passenger lift.
● People's rooms were personalised with their own belongings, where possible, so they reflected their individual preferences.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet
● People's health conditions were being managed, and staff engaged with external healthcare professionals including GP's, district nurses and other professionals when necessary.
● People were supported to attend regular health checks and see health professionals when required.
● People were supported to eat and drink enough to maintain a balanced diet. People's preferences were known by staff. Staff ensured people had access to regular drinks and snacks as required. All meals prepared were homemade.

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.

● Capacity assessments were completed to assess if people were able to make specific decisions independently. For people who lacked mental capacity appropriate applications had been made to obtain DoLS authorisations, when restrictions or the monitoring of people's movements were in place.

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, under the previous provider, 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.

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

- Staff did not always promote people's independence and encourage people to take part in daily activities in the service, such as cooking.
- People's care plans did not detail how staff could support them to increase their independence. People were not given the opportunity to try new experiences or develop new skills.
- Staff spoke warmly about the people they cared for. However, staff were observed talking and treating people in a parental way. 1 relative told us, "Yes, I think they are caring. Some of the staff have a more parental approach with [name]."
- Staff did not always ensure people were protected from exposure to any environmental factors they would find stressful. 1 person, whose care plan detailed a sensitivity to a loud television or radio, spent most of the day in the main lounge where the television was turned up high.
- Staff responded in a compassionate way when people were exhibiting emotional distress. However, we were concerned the lack of robust recording of these events left people at risk.

The lack of person-centred care plans placed people at an increased risk of not having their needs met. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People received kind and compassionate care from staff. Staff knew when people needed their space and privacy and respected this.

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

- People were involved in decisions about their care and support upon admission to the service. However, there was no evidence people had been involved in developing or reviewing their care plan. This meant people's wishes about how they wanted their care delivered may not have always been known.
- Regular resident meetings meant people were empowered to make decisions about the service when appropriate and felt confident to feedback on their general care and support.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection, under the previous provider, 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; 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

- During our inspection we observed people sitting in the lounge with the television on and very little to do. People became agitated with each other and shouted at each other. 1 person told us, "I give up, can't do a thing today, don't go anywhere, don't do anything."
- We asked staff whether the channel was what people wanted to watch. Staff told us [name] loves quiz shows and it keeps [name] quiet. This meant we were not assured people using the service were stimulated to improve their physical and mental well-being or that their choices and preferences were respected.
- People were not always supported to engage in activities which were socially relevant to them. The activities plan displayed on the communal notice board included activities such as talking to other residents or watching television. This meant we were not assured the model of care within the service promoted people's wellbeing.
- People new to the service had not been added to the activity timetable and people who had died had not been removed.
- Sufficient opportunities for people to engage in community-based activities that were relevant to them, had not been provided. Although we saw some examples of activities taking place, such as supporting people to access the community and organising one-off celebrations for birthdays, more could be done to ensure people were able to try new things and experiences.
- There was little evidence of people's protected characteristics being assessed and addressed for example religious and cultural backgrounds. 1 person told us they liked to attend church, however, there was no explanation given as to why staff had not supported this person to do so.
- The local authority paid additional money for people to have specific hours of staff support for activities each week. However, there was no evidence provided to show whether people received their agreed hours and how their time was being spent.
- People who were living away from their local area, were not supported to stay in regular contact with friends and family. 1 person had lived with their sibling at a previous placement, but no explanation was given as to why this relationship was no longer supported.

There was a lack of evidence that care provided met people's needs and reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Preferences (i.e. gender of staff) were identified and appropriate staff were available to support people.

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 was no information made available to people in alternative formats. For example, in 1 person's file we read they did not speak. There was no information provided in an accessible format to this person and within their communication log there was no meaningful information or guidance on how to effectively communicate with this person.

The lack of person-centred care plans placed people at an increased risk of not having their needs met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● During the inspection, the manager was unable to provide evidence of any complaints or concerns received about the service. The manager could not demonstrate the process they would follow in the event of a complaint. Therefore, we were unable to confirm whether any improvements would have been made in response to complaints, concerns and safeguarding alerts.

End of life care and support
● Only 1 person's care plan contained detailed information about how to support them with their end of life journey. Advanced decisions were not clearly documented for other people. This meant staff did not have all relevant information to ensure people's last wishes were upheld.
● Not all staff had received training on death, dying and bereavement. This left people at risk of being supported by staff without the correct skills and knowledge.

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, under the previous provider, 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not maintained accurate, complete and contemporaneous records for all people using the service. Full assessment of people's needs and potential risks had not been carried out.
- The provider had not ensured all staff had completed relevant online training to safely support people using the service .
- There was a lack of emphasis on positive outcomes for people in care plans and staff had not been provided with training or information about Right support, right care, right culture.
- The provider did not have a clear vision for the direction of the service which demonstrated a lack of ambition and desire for people to achieve the best outcomes possible. The culture in the home was not person-centred and empowering.
- There was limited evidence that the service had been achieving the best outcomes for people. People and their relatives/representatives were not always consulted regarding the development and review of their care plan.

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

- The provider had not implemented a robust audit and governance system to effectively monitor the service. We found issues with staffing, person-centred care, risk management, medicines and infection control which had not been addressed effectively by the provider.
- Governance systems did not enable risks associated with service users care needs to be identified, reviewed and updated in a timely manner. Where risk assessments needed updating or additional information was required this was delayed, leaving services users at potential risk of harm.
- The manager did not always fulfil their responsibility to be open and honest and give all relevant people information when things went wrong. The local authority or the Care Quality Commission had not been informed of a number of incidents which had occurred at the service.

Continuous learning and improving care

- The provider failed to ensure sufficient oversight of accidents and incidents at the service. Where incidents had occurred, relevant information had not been shared with other individuals or bodies, such as the local authority safeguarding team or the Care Quality Commission. Shared learning from accidents and incidents

had not occurred.
● The manager had been conducting monthly audits of the service, but these had not been effective. Provider visits and the routine audits carried out by the manager that made up the quality monitoring cycle, were not being transferred into ongoing improvement and development of the service. Where risks had been identified, action had not been taken to address those risks to protect service users and staff from the risk of harm.

All of the above demonstrates a failure to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The service worked in partnership with other professions such as social workers, mental health team, learning disability team and speech and language therapists. The service worked closely with the local GP surgery and other health professionals.

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 failed to ensure people received appropriate care and treatment that reflected their personal needs and wants.

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 failed to implement robust procedures to protect people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff to adequately meet peoples needs. Staff were not suitably trained to fulfil the requirement of their role, placing people at risk of harm.