N H Care Limited

Summerfield House

Inspection report

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Date of inspection visit:
03 August 2021
04 August 2021
10 August 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Summerfield House is a residential care home providing personal care for up to five people with a learning disability or autistic spectrum disorder. At the time of inspection four people were living in the home and one person had temporarily moved back to their family home.

People's experience of using this service and what we found
People were not protected from abuse. Incident records detailed physical, verbal and emotional abuse which had not been responded to. There had been no action taken following the incidents to prevent reoccurrences and ensure people were protected from the risk of abuse.

There was a widespread lack of recognition from the staff and provider about the inappropriate and abusive practices being undertaken. The culture of the service was such whereby incidents of abuse, resulting in harm, were deemed as normal.

The registered manager and provider had failed to ensure that monitoring and governance systems and processes were established and operating effectively to ensure compliance with the regulations. The provider failed to ensure there was effective and consistent managerial and operational leadership in place. The home presented with a closed culture meaning poor culture that led to harm, including abuse.

There had been no safeguarding alerts made to the local authority safeguarding team for numerous allegations of abuse. There had been no consideration of notifications needing to be made to the CQC in line with legal requirements.

Care plans and risk assessments weren't always updated to consider how to support people. People were not supported to be involved or make decisions about their care. We were not assured of good infection prevention control practice in relation to COVID-19.

There were widespread concerns that people were not treated with dignity and respect. Staff practice, language and records were demining and derogatory to people. There was little understanding from staff in regard to poor practices and the impact on people's wellbeing.

Care was not personalised to meet people's needs, preferences, interests and give them choice and control. People were not involved in developing their care plan and their individual needs and circumstances were not considered. The registered manager and provider had not taken appropriate steps to comply with the Accessible Information Standard to ensure people's communication needs were met.

There were widespread and significant shortfalls in the care, support and outcomes that people experience. The registered manager and provider showed a lack of understanding of how to apply the Mental Capacity Act 2005. The home did not work with professionals to ensure effective outcomes for people.

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.

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

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The model of care did not maximise people's choice, control and independence. Care was not person centred. The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives. This meant people did not receive person centred care, the provider and staff did not do all that was reasonably practicable to make sure peoples care and treatment was appropriate, met their needs and they had choice. We took action to address this. Full information about CQC's regulatory response to the serious concerns found during this inspection is added to the report after any representations and appeals have been concluded.

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

Rating at last inspection
The last rating for this service was good (published 04 September 2019).

Why we inspected
The inspection was prompted due to concerns received about abuse. 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.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

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

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 safe care and treatment, safeguarding people from abuse, person centre care 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Summerfield 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 undertaken by three inspectors and an assistant inspector. Three inspectors visited the home for one day whilst an assistant inspector made telephone calls to staff. One of the inspectors was on site for a short period of time to use a symbol-based communication tool.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by speaking to professionals involved in peoples care. In this report, we used this communication tool with two people to tell us their experience

One inspector visited the home on another two occasions.

Service and service type
Summerfield 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 was absent throughout the first two days of inspection and then resigned. They have applied to deregister with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We observed and/or spoke with four people who used the service about their experience of the care provided. We received feedback from two professionals. We spoke with the independent consultant who was supporting the home. We spoke with 13 members of staff including the director, nominated individual, acting manager, team leaders and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two 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 and check people were safe. We spoke with local authority safeguarding and commissioning teams.

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 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
• During the inspection we found significant concerns regarding people's safety. People were not protected from abuse. Records showed incidents of physical, verbal and emotional abuse which had not been responded to. This abusive practice had occurred between people living in the home and abusive practices by staff.
• Records showed staff making threats to cancel people's activities, call the police when people were anxious and on one occasion use furniture to prevent a person from moving. The staff response and approach to these incidents demonstrated a significant lack of understanding about people's needs and the safe management of anxiety.
• There had been no action taken following incidents of abuse to consider what could be put in place to prevent reoccurrences and ensure people were protected. There was no record that any staff discussions had taken place to consider the management of incidents and to discuss inappropriate and abusive staff practices.
• The culture of the service was such whereby incidents of abuse, resulting in harm, were deemed as normal. This meant people were exposed to the risk of harm and abuse including verbal, emotional and physical abuse.
• Staff had not always recognised abusive practice and staff and the registered manager had not taken action to safeguard people. We observed a person being hit on the head by another person, this was not recognised as a safeguarding incident and no immediate action was taken to safeguard either person or consider how to prevent this happening again.

A failure to ensure people are protected from abuse 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.

After the first two days of inspection, we took urgent action to keep people safe. In addition, the local authority agreed for an external agency to provide managerial support in the home to ensure incidents were managed safely and safeguarding allegations were reported. We went back to the home to check and found there had been a further four allegations of physical abuse. The provider had not taken any action to consider what could be put in place to prevent further reoccurrences. All the people living in the home were supported to move out.

Assessing risk, safety monitoring and management; Preventing and controlling infection
• Where it was identified people were at risk of choking, there were insufficient risk assessments in place. This meant people were exposed to risk of harm.

• Care plans and risk assessments weren't always updated to consider how to support people at times of heightened anxiety. There was some information about people's known risks but there was a lack of assessment and mitigation. This meant staff did not always have the most up to date information about people.
• We were not assured of good infection prevention control practice in relation to COVID-19. This meant people and staff were not protected from the risk associated with COVID-19. There were no risk assessments for staff relating to the risks associated with COVID-19. Service user risk assessments did not consider people who were of an ethnic minority background. This meant we did not have assurances about how risks relating to staff and people, in relation to COVID-19, were being managed.
• There was no policy for visitors to the home to consider the risks associate with COVID-19. Staff told us visitors would visit the garden accessing it through the home, visit in people's bedrooms and visit in the communal lounge and mix with people.
• Some staff were observed to not be wearing masks as per the government guidance. In addition, there was no allocated area for staff to put on and take off their personal protective equipment (PPE), which meant they were entering the home without washing their hands or wearing PPE.
• Staff and people were being tested for COVID-19. However, staff were completing lateral flow tests on site after they had arrived on shift and entered/spent time in the building. There was no risk assessment for this practice to consider the risks if someone tested positive.

A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the first two days of inspection, we took urgent action and asked the provider to ensure the risks associated with choking and COVID-19 were assessed and mitigated. We went back to the home to check and found there the risk assessment for the person who was at risk of choking had not been updated and visitors had been in the home without adequate assessments. In addition, staff were still not wearing PPE in line with government guidance. All the people living in the home were supported to move out.

Staffing and recruitment
• Generally, staff recruitment was carried out safely. However, we did find gaps in one staff members employment history that did not have an explanation.
• No one raised concerns about staffing levels in the home and rotas reflected consistent numbers of staff on each shift.

Using medicines safely
• Where staff had administered 'as needed' medicine to people, that were prescribed for anxiety, they had not always recorded the reason why. This meant there was no way to establish if they had been given in line with the protocol.
• Where people had 'as needed' medicines there were protocols in place to guide staff about when to administer them. However, one protocol did not contain details of a safe time gap between doses. We discussed this with the team leader who contacted the prescriber to establish what the safe time gap was.
• Generally, people's day to day medicines were managed safely and people received their medicines as prescribed.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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; Supporting people to eat and drink enough to maintain a balanced diet

- There were widespread and significant shortfalls in the care, support and outcomes that people experienced. A professional told us, "It feels institutionalised and lacks care."
- People's care and support was based on ill-informed information rather than a full assessment of people's needs. People's care plans stated they had not been involved in reviews due to their learning disability and inability to retain information, therefore their care was planned based on past assessments and history. There was no evidence to suggest if any attempt had been made to involve people or seek their views or opinions when assessing their needs. This meant people's wants needs and preferences were not taken into consideration when the care was planned and assessed.
- A staff member told us people had not been involved in decisions about what they ate and drank. On our third day of inspection, a staff member told us they were now able to offer people a choice in what they ate (after the independent consultant had started in the home). The staff member said up to that point the menu had been set and people did not have a choice. The nominated individual said people did have a choice of food and are consulted in this area however no evidence was presented to reflect this.
- Care records showed people's protected characteristics, as identified in the Equality Act 2010. This included people's gender, age, culture, religion, ethnicity and disability, however there was no care plan to indicate what support people may need in relation to these areas, such as their religion.

A failure to ensure peoples care and treatment is appropriate and meets their needs was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

• The registered manager and provider had not kept accurate records in relation to decisions made on behalf of people. For example, a 'consent to care' document had been signed on behalf of people. There was no indication the person signing the form had the legal authority to do so.
• Mental capacity assessments had been completed but were not decisions specific and did not indicate who had completed them. For example, a person's capacity had been assessed for nine separate areas of need, in one document. These included medical support, oral care and what they wanted to wear that day. This meant there had been no consideration for how the person may be able to make decisions in each individual area.
• DoLS applications had been made and authorised for people where needed.
• Records indicated people were able to refuse certain aspects of their care, staff confirmed this. There was no indication anyone was being illegally restricted.

The failure to ensure records are complete, detailed and accurate was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• A professional told us the home did not work with them to ensure effective outcomes for people. The professional said, "I've asked them [registered manager] to implement strategies and they haven't. None of the staff have seen [plan] or had any discussion about the recommendations we made." The professional went on to tell us they had assessed the person in 2018, and as of July 2021 when they visited the home, staff had never seen the assessment, plan or recommendations. When we visited the home, none of the documentation was in the persons care plan and we saw poor staff practices.
• There was no care plan to detail what support each person needed to maintain their oral health.

Staff support: induction, training, skills and experience
• Training schedules reflected that staff had received training but some of this was out of date. Out of date training included adult safeguarding and we saw poor staff practice in relation to this and it was not recognised by the staff or management team. The nominated individual said that staff had recently completed safeguarding training and training in specific communication methods but did not supply any evidence of this.
• One person's review from an external health professional in 2019 indicated staff needed training in managing behaviour but the provider was not able to produce any records to show staff had undergone this. In addition, we saw poor staff practice in relation to how staff supported people at times of distress.
• A professional said, "There is a massive disconnect between their [staff] understanding of the behaviour in relation to the lack of activity and communication. They [staff] don't associate the two. They don't understand the impact of people's autism and the complexity of needs."
• Records indicated staff had received an induction when they started work at the home and then received supervisions. However, there was no indication poor practice had been raised or addressed in any formal or informal meeting.

Adapting service, design, decoration to meet people's needs
• There was one lounge and one kitchen diner for people to use as communal shared areas. The provider had not considered the compatibility of people when they accessed the communal areas of the home and therefore not carried out any assessments to consider where the environment may have an impact on people. A professional fed back to us they had seen a person retreat to their bedroom as it appeared, they did not feel comfortable in communal areas of the home.

• The home did not have a homely feel. There was a number of areas of maintenance that needed to be completed including holes in the stairs carpet and worn paint work exposing the surface below.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity
• There were widespread concerns that people were not treated with dignity and respect. Staff practice, language and records were demining and derogatory to people.
• People were not treated with kindness and compassion on a day to day basis. Records reflected staff reprimanding people when they became anxious and staff practice increased people's anxieties.
• Interactions between staff and people were task focused. Observations and records showed staff did not encourage or listen to people in a compassionate and supportive way. This meant staff did not understand the importance of listening and acting on people's preferences, instead the priority being given to day to day duties. There was little understanding of the impact of this approach on people's wellbeing and needs.
• One person's records indicated the staff needed to ensure the person knew they were valued; however, the staff practice directly contradicted this with records demonstrated threats and punishments made to the person. This meant staff did not follow the persons care plans to ensure they were supported in a way that made them feel like they mattered.
• One person had been asking to move out of the service, records going as far back as 2017 indicated they wanted to leave. They wanted to live with a same sex group and have more independence. No action had been taken to support the person with this.
• The provider was not able to demonstrate they were meeting the right support, right care, right culture guidance. People's care did not maximise their choice, control and independence. Care was not person centred. The ethos, values, attitudes and behaviours of leaders and staff did not ensure people living in the home led confident, inclusive and empowered lives.

A failure to ensure peoples care and treatment is appropriate and meets their needs was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
• People did not receive person centred care. The registered manager and provider failed to ensure they did all they could to make sure people's care and treatment was appropriate, met their needs and they had choice.
• The registered manager and provider had failed to work with people to support them to make decisions about their care and consider their needs and preferences. There was no evidence people had been supported to understand their care plans and risk assessments and there was no evidence people had been

given a choice in how they were supported or what their needs or preferences were according to them.

A failure to ensure peoples care and treatment is appropriate and meets their needs was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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; Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care was not personalised to meet people's needs, preferences, interests and give them choice and control in line with the right support, right care, right culture guidance.
• People were not involved in developing their care plan and their individual needs and circumstances were not considered.
• We heard a person ask three times for staff to support them with social areas of their life. Staff response was they would "have to wait for a meeting with everyone to discuss that." The person had also been asking about social support in regular meetings with staff and there were minutes of these meetings. No action had been taken to support the person to enhance their social life and no consideration was given to the social isolation the person may be experiencing.
• People's wants, needs and goals were not consistently recorded. There was some information about people's goals, but it was not clear if they had been involved in setting the goal and there was no plan on how they could achieve it. This meant there was a failure to work with people to support them to make decisions about their care and consider their needs and preferences.

A failure to ensure peoples care and treatment is appropriate and meets their needs was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The provider and registered manager had not taken appropriate steps to comply with the Accessible Information Standard to ensure people's communication needs were met.
• One person used sign language as a form of communication, although some staff said they had been trained in this, the training was not consistent across the team, we were not provided with any training records. We did not observe any staff using sign language on any of the three days we visited. A professional said, "They [staff] don't recognise the importance of [sign language], so they think [person] can verbally communicate."

• Accessible communication methods were not always available to people. Where people's external assessments identified they needed additional communication methods, these were not present. A professional said, "They [staff] have visual pictures but they are not visible or used."
• People's care plans had not been adapted into a way that would enable them to understand what care had been planned or how they could contribute to the planning of their care.

Improving care quality in response to complaints or concerns
• There was no evidence people had been asked to express their views about their care and support and there was no information in people's care plans about how they could make a complaint.
• There was no evidence people had been given a copy of a complaints policy or procedure in a format that was accessible to them and they could understand.
• There was no record of any complaints having been made.

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 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

- The registered manager and provider had failed to ensure that monitoring and governance systems and processes were established and operating effectively to ensure compliance with the regulations.
- The provider failed to ensure there was effective and consistent managerial and operational leadership in place. This resulted in unsafe care practices, which were not being monitored to ensure people were protected from harm. In addition, there were allegations of abuse, unsafe care practices and people not being involved and given choice. This exposed people to risk of harm and abuse.
- The home presented with a closed culture meaning poor culture that led to harm, including abuse. The governance systems did not identify or addressed the serious issues in relation to the failure to recognise and report abuse as well as inappropriate and abusive staff practice. The provider had failed to recognise the use of practice which amounts to threatening and punitive behaviour to people.
- People were not always receiving appropriate care that reflected their choices, needs and considered their preferences. The provider failed to have systems and processes in place to ensure people received their care in a dignified and respectful way. This meant people's care was provided in a way that was not personalised, appropriate and person-centred.
- Provider audits had taken place in February and May 2021. These audits did not identify the concerns we found. This meant audits fail to identify abuse in the home and failed to ensure people were cared for safely and were not exposed to abuse and inappropriate care by the staff team.
- Systems and processes to monitor COVID-19 prevention were ineffective. Staff practice, risk assessments, the environment and visitation guidance was inadequate. The provider was not aware the home was not up to date with current government guidance on how to manage the impact of COVID-19 and had not identified the issues we did. This meant staff and people were exposed to the risks associated with contracting COVID-19.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager lacked the skills, competence and knowledge to manage the carrying out of the regulated activities. This was a breach of regulation 7 (Requirements relating to registered manager) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the first two days of inspection, we took urgent action to keep people safe. In addition, the local authority agreed for an external agency to provide managerial support in the home. We went back to the home to check and were not satisfied the providers governance and oversite was adequate. All the people living in the home were supported to move out.

• Notifications had not been submitted to CQC in line with legal requirements. We are reviewing the potential failure to notify and will report on this once completed.

Continuous learning and improving care; 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 registered manager and provider had not shown transparency when things had gone wrong. They had failed to recognise or investigate incidents to prevent reoccurrences and failed to communicate to professionals and families when incidents had occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There was no evidence staff were supported to question practice and raise concerns. Although staff told us they understood safeguarding and whistleblowing practices, they had not recognised or reported the abusive practise we found.
• The home did not have any evidence they enabled and encourage accessible open communication with people using the service. There was no evidence people's views and experiences had been gathered.

Working in partnership with others
• The provider and registered manager had failed to communicate to external agencies about incidents that had occurred in the home. In addition, a professional said they did not feel the home worked in partnership with them, they said, "We don't get any contact from the home about issues."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure care and treatment was provided in a safe way.

The enforcement action we took:

We cancelled the 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 care and treatment was provided in a safe way.

The enforcement action we took:

We took urgent action and imposed conditions on the 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 protected from abuse.

The enforcement action we took:

We cancelled the 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 protected from abuse.

The enforcement action we took:

We took urgent action and imposed conditions on the providers registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers governance systems have not identified or addressed the serious issues in relation to their failure to recognise and report abuse, inappropriate and abusive staff practice and a failure to deliver person centred care.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers governance systems have not identified or addressed the serious issues in relation to their failure to recognise and report abuse as well as inappropriate and abusive staff practice.

The enforcement action we took:

We took urgent action and imposed conditions on the providers registration.