Slough Borough Council

Lavender Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Lavender Court is a residential care home providing personal care to seven people with a learning disability in one adapted building. At the time of our inspection seven people were supported.

Not all aspects of the service have been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service is registered to support up to seven people. This is larger than current best practice guidance. However, the size of the service was mitigated by the building design and a refurbishment of the premises in 2019, which reduced the number from eight to seven. There was no signage to indicate it was a care home and staff did not wear uniform that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
People did not consistently receive safe care and support. The registered manager had not routinely ensured they were up to date with national guidance and did not always keep accurate records in relation to risk management. Staff did not always mitigate potential risks to people.

Incidents were not always escalated appropriately by the registered manager or reported to the safeguarding authority. The service did not always operate systems effectively to ensure suitable staff were recruited or make sure staff had the right training to support people safely. Systems were not always in place to ensure the effective management of medicines which meant people were at risk of not receiving their medicines as prescribed.

Systems were either not established or operated effectively to monitor and assess the safety of the service or standards of care. Several key policies and procedures were not in place to provide staff with clear processes to maintain good standards of care. Audits completed by staff to check the quality of the service did not always identify or address areas to drive improvement. Records in relation to people's information and the management of the service were not always accessible, complete or up-to-date.

Relatives were positive about the standards of care provided however, communication from the provider and registered manager was inconsistent. For example, relatives received formal correspondence about a significant event but did not receive written guidance about the management of covid-19 or visiting agreements.

Processes to manage the risk of covid-19 were established and implemented by staff to reduce the risk of

infection. Relatives told us they felt their family members received safe care and had no concerns about staff practice. Staff were positive about team collaboration to meet people's needs and generally felt supported.

The service didn't always (consistently) apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. Care provision was not always designed to meet people's personalised needs. Staff did not receive specific training for managing people's behaviours that challenge. There were no systems in place to monitor whether positive behaviour support plans were implemented effectively or continued to meet people's individual needs.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 15 January 2019) with two breaches of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 17, 18, 22 and 30 October 2018. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We identified concerns in relation the governance and risk management of the service during our contact with the service following our emergency support framework engagement call. We undertook this focused inspection to check these areas of concern, to make sure they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains Requires Improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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 and improper treatment, fit and proper persons employed, duty of candour, failure to notify CQC of certain

events, 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Lavender Court

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.

Inspection team
The inspection was undertaken by two inspectors. One inspector visited the service and another inspector made phone calls to relatives of people living at Lavender Court and staff members. The inspection activity was over four days, including two days of on-site visits and remote meetings with the registered manager.

Service and service type
Lavender Court 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.

Notice of inspection
We announced the inspection at very short notice; this was to have some preliminary discussion around the use of Personal Protection Equipment (PPE) and maintaining social distancing on inspection.

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. 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. We considered the

information received from the provider in response to our Emergency Support Framework (ESF) call on 24 June 2020.

During the inspection
People's needs and communication difficulties meant we were not able to seek direct feedback from people. Opportunities to observe staff supporting people were limited due to covid-19 risks. To gain a balanced view we attempted to make contact with all relatives and professionals who were involved with the service. We spoke with four relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, senior care worker, care workers and an agency member of staff. We received written feedback from three professionals from the community learning disability team.

We reviewed a range of records. This included four 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, such as health and safety compliance certificates and checks, incident reports and infection control protocols were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and policies and procedures. We received feedback from two professionals who had been involved with the service after our inspection.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Risk assessments were completed in response to people needs. However, the provider's risk assessment policy and procedure was not implemented effectively to accurately identify specific hazards, the level of risk posed for each hazard, or safe measures to reduce the risk. This meant there was not enough information for staff to effectively manage risk to keep people safe.
• One person's meal time risk assessment stated that staff supervision was required due to their behaviour, but did not identify the risk of choking or safe measures where a swallowing assessment was in place. Two staff we spoke with were not aware this person was at risk of choking, which put the person at potential risk of harm.
• Fire evacuation plans were in place for each person. However, in the event of a fire, one person's plan instructed staff to leave them in their bed with the door shut. This strategy put the person at risk of harm and is against government guidance on fire safety, which says evacuation plans should not rely on the fire service to rescue people.
• A bed rail risk assessment did not include checks about the correct fitting to ensure safety. It did not address whether bed rails were appropriate to meet the person's needs.
• There were several incidents of physical violence from one person towards others. However, no action was taken to risk assess whether physical intervention was appropriate as a last resort to protect people where less restrictive measure were unsuccessful.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said they would take action to review and amend people's risk assessments.

At our last inspection we recommended the provider improved health and safety risk assessments and checks. Not enough improvement had been made.

• Health and safety risk assessments for work activities and the premises did not include enough detail to identify specific hazards and relevant safe measures. For example, risks associated with the control of substances hazardous to health did not identify hazardous materials in use, or specific safe measures for staff to follow.
• One member of staff had been absent from work for more than seven days due to a work-related injury. The registered manager could not recall if a report about this had been sent to the health and safety executive as required. They agreed to raise this with the provider's health and safety team to take action.
• Water safety documentation, including monthly water temperatures or water storage flushes, were not consistently completed by contractors in line with service procedures. This meant the registered manager could not be assured the required checks were completed to prevent legionella. They informed us the water had tested as positive for low level of legionella in June 2020 but could not tell us what remedial action had been taken. When we checked the sample certificate, we found legionella had not been detected. The previous samples, dated 12 June 2019, were not available and the registered manager was unaware of the results.

We found no evidence that people had been harmed however, health and safety risk assessments and checks were either not in place or robust enough to demonstrate risk was effectively managed. 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.

The registered manager agreed to take action to clarify health and safety checks and remedial actions with the provider's facilities department.

• Other compliance checks such as portable appliances, electrics, fire safety equipment and gas safety were completed.
• Staff completed a range of regular health and safety checks in relation to the premises and equipment. Equipment such as a hoist and profile beds were regularly serviced to make sure they were in good working order and safe to use.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we recommended that local safeguarding procedure were implemented for the service. Not enough improvement had been made.

• Systems were not established and operated effectively to investigate potential safeguarding concerns.
• The service safeguarding procedures for staff did not reflect current definitions of abuse in line with the Care Act 2014 or the provider's policy and procedure in relation to self-neglect, domestic violence or modern slavery. There were two different procedures; one instructed staff to record what indicators of abuse they had observed, and actions taken, and another procedure told staff to record injuries on a body chart but did not refer to the incident reporting system. This was contradictory and confusing for staff. Two staff told us they only completed body charts for injuries.
• We found several unexplained injuries documented on body charts, which were not appropriately recorded, reported or investigated by the service. There had been a number of incidents of physical assault between people and one instance where injuries were sustained by one person using the service, which were not reported to the safeguarding or funding authorities. This meant external agencies were not able to make their own enquiries, or to check whether appropriate action was taken to safeguard people.
• The registered manager told us they knew about some of the injuries and incidents of physical assault. They could not provide a satisfactory explanation about why these were not reported in line with safeguarding requirements. Upon reflection the registered manager told us they should have taken action.

• One member of staff told us they thought the unexplained injuries were a result of poor recording and lack of audit trail, rather than a sign of potential abuse. For example, when one person was observed to accidently knock themselves into objects this was not currently recorded by staff. The staff member said they would raise this with the registered manager.

Systems were either not in place or not operated effectively to investigate allegations or evidence of abuse. This exposed people to potential ongoing harm. 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.

We raised safeguarding referrals to the local authority directly in relation to three people. We continue to follow-up with the registered manager to make sure they are working with relevant professionals to protect people. The registered manager said they would take action to review reporting protocols.

• Staff received safeguarding training and those we spoke with demonstrated understanding of indicators of abuse and understood their duty to report concerns.
• Relatives told us they felt their family members received safe care and said staff would keep them informed of any concerns.

Staffing and recruitment
• Recruitment procedures were not always operated effectively to make sure staff of good character were employed. The registered manager failed to ensure that information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed.
• Two staff recruitment files showed full employment history was not sought as required. The provider's policy and procedure stated staff must have two references from the most recent employers (specifically not colleagues). Only one such reference had been obtained for both staff. There was no record of the director approving staff appointment without the required references in line with the policy and procedure.
• Staff health questionnaires relevant to their role were not available during our inspection in line with requirements. These were eventually obtained by the registered manager from their Human Resources department and electronically provided to us after our inspection.
• Agency staff profiles detailing recruitment checks, experience and qualifications were not held on file. The registered manager told us these were held centrally and could not demonstrate how they checked these prior to agency staff working at the service to make sure they were suitable.
• Agency profile stated they had competed mandatory training but did not list what training courses or the date of these courses. The provider did not have a system in place to audit and check this information.

Recruitment procedures were not operated effectively to make sure suitable staff were employed. This exposed people to potential risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said they would take action to implement recruitment procedures.

At our last inspection we recommended the service sustains appropriate staff training and supervision and implements a robust system to monitor this. Not enough improvement had been made.

• Staff had not received specific training for managing behaviours that challenge or physical intervention to keep people safe in a crisis. When we asked staff about a person's positive behaviour support plan, they had a basic awareness of strategies they used in practice such as using a person's video to distract them and separating people. However, one staff member said, "I ask [the person] not to do it and tell them it not

acceptable and ask to apologise" which was not an appropriate response or line with the person's positive behaviour support plan.
• Staff did not receive annual medicines competency assessments to check their knowledge and skills. These were completed in response to staff medicine administration errors.
• Seven staff members' moving and handling training had lapsed during the pandemic due to the suspension of classroom-based training. The registered manager had not considered how to make sure staff continued to have the knowledge and skills required to provide safe care. They had not accessed available online training through Skills for Care or completed competency assessments. This was mitigated through staff allocation to ensure only staff up to date with their training supported the person with this need.
• There was no specific training pathway for the registered manager; they completed the same mandatory training as care workers. The registered manager had not received higher level training for health and safety management, specific water hygiene training or managing risks. They had completed a higher level of safeguarding training in 2015 but had only refreshed with basic knowledge since then. This level of training was not proportionate to their role or responsibilities to manage risk safely.
• Staff new to care attended sessions to obtain their Care Certificate. This is a set of skills and behaviours expected of care workers to perform in their role. However, there was no process to assess staff competency in the workplace, which is essential for achieving the Care Certificate.

The service did not ensure that staff received the training required to meet people's specific needs safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said they would take action with the provider to address staff training.

At the last inspection we recommended an appropriate tool was implemented to determine and evidence safe staffing levels and deployment. Improvement had been made in this area.

• The service had worked with commissioners to review people's needs and the level of staff support required using an appropriate tool. This had led to an increase in staffing levels, which was reflected in staff rotas.
• Staff told us the workload was manageable with comments such as, "Management make sure the numbers of staff required are available on each shift" and "Since covid we have had more to do than the usual, but we are still able to keep [people] safe from harm."
• One member of staff told us they did not have as much time to spend with people due to increased cleaning schedules. To help alleviate this day centre staff provided activities to people in their home and visits to the local community.

Using medicines safely

At our last inspection we recommended the service implemented national guidance in relation to the administration and management of medicines. Not enough improvement had been made.

• The registered manager had made attempts to improve the administration of medicines policy and procedure' and sought further advice from a pharmacist. However, they had not implemented this advice due to other covid-19 pressures. The policy and procedure continued to lack key information such as, frequency of staff medicine training and competency assessments, safeguarding reporting and when required (occasional) medicines protocols in accordance with the National Institute for Health and Care and Excellence (NICE) 'Managing medicines in care homes', 2014, guidance.
• When required medicines protocols were not in place for people, except for emergency epilepsy medicine

written by the community healthcare team. This meant there was no clear guidance for staff to follow about the use of these medicines to ensure safe administration.
• Some people were administered medicines with food. It was recorded in their medicines care plan this was not covert administration, rather to assist with swallowing tablets more easily, which was explained to people. However, the service had not checked with the prescriber or pharmacist whether there was any risk of contraindications when taken with food, which could affect the efficacy of medicines.
• There were no systems to monitor, review and learn from medicines administration errors or other discrepancies. We found two medicines administration errors of the wrong doses given to people. People had not suffered any adverse effects and the number and frequency of errors was not concerning. However, there was a failure to investigate and learn lessons to prevent reoccurrences. When we raised this with the senior care worker, they could clearly recount action taken and we were provided with some evidence contained in daily notes, but there was no audit trail that set-out the rationale for action taken.
• The stock reduction system was not always implemented effectively, which was not identified through the monthly medicines audits completed by staff. There was no evidence that people had run out of medicines, however this was a potential risk if stock was not properly managed.

Safe medicines procedures were not always established or implemented which put 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.

Preventing and controlling infection
• The registered manager had not taken account of government guidance and considered the risk of covid-19 transmission from agency staff working in other care homes. They agreed to review this with the provider who was responsible for sourcing agency staff to consider and implement this where ever possible.
• Staff told us increased cleaning schedules were in place and records confirmed this. Staff had access to personal protective equipment and knew what type of PPE was required and how to don and doff to protect people and themselves from the risk of infection.
• There was a clear protocol for testing and recording people's and staff temperature regularly as well as visitors to the home, where this was considered essential. Hand washing facilities and hand sanitiser were easily accessible.
• Due to government delays with testing kits, whole home testing for covid-19 had not yet occurred. Two people had presented with symptoms early in the pandemic and were tested as negative.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to establish or effectively operate systems or processes to ensure compliance with the requirements of the fundamental standards. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider had not established systems to robustly monitor the safety and quality of the service or compliance against regulations.
• The registered manager was not always clear about their responsibilities or regulatory requirements. They had not notified CQC about deprivation of liberty authorisations or incidents which met the criteria for safeguarding referrals.
• Checks and audits completed by the service failed to identify areas we found during our inspection. For example, the registered manager had delegated audits in relation to medicines and did not check potential themes or whether the audit was implemented effectively.
• The provider had not established key relevant policies and procedures, such as, administration of medicines, management of people's monies, bedrails, duty of candour and mental capacity act and deprivation of liberty safeguards. This meant there was a lack of direction from the provider, or processes for staff to follow, which put people at risk of poor standards of care. The registered manager had attempted to write some of these policies and procedures, however these were not always fit for purpose.
• The provider failed to ensure there was a transparent policy on the use of restrictive interventions, including a restrictive intervention reduction programme. The provider had not audited challenging behaviour incidents or other positive behaviour support (PBS) plan outcomes in line with government guidance.
• The provider completed reviews of incident reports submitted to them, however this process did not analyse data. There was no scrutiny by the provider about whether action taken by the registered manager was appropriate.
• The registered manager was not up-to-date with government guidance about the management of Covid-19 in care homes. For example, the visitor's policy and procedure had not been reviewed or amended since

April 2020 to account for government guidance. They were not aware of government guidance to complete individual staff risk assessments, or updates about the specific use of PPE in care homes. The registered manager said they had regular meeting with the provider's leadership team to review covid-19 guidance and did not know how this was missed.
• People's information and management records were not always accessible, complete or contemporaneous. For example, current health and safety compliance records were not on file. Whilst there was evidence the service applied mental capacity and best interest principles, this was not completed on the relevant pro-forma as a full record of actions taken and outcomes. A professional involved with the service commented that requests for documentation was not always provided in a timely manner.

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

The service failed to notify the Commission of specific events. This was a breach of regulation 18 (Notifications of other incidents) of the Registration Regulations 2009.

The registered manager said they would raise concerns with the provider to agree actions and make improvements.

• The senior care worker demonstrated they were knowledgeable about people's needs. We observed they provided staff with support and clear direction during their shift and had close over-sight of covid-19 protocols to keep people safe.

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 have a duty of candour policy and procedure to encourage an open and transparent culture at the service. The registered manager knew their responsibilities under the duty of candour but could not demonstrate systems in place to support this.
• We were concerned that the lack of reporting to safeguarding or notifying CQC showed the registered manager was unlikely to exercise their responsibility to meet the duty of candour in relation to notifiable safety incidents.

We found no evidence of notifiable safety incidents however, systems were not in place to demonstrate how the provider would ensure the duty of candour was fulfilled. This was a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others
• Since our last inspection there had been no people's or relatives' surveys to gain their feedback. Weekly residents' meetings were facilitated by staff; a new Gazebo had been purchased to meet people's wishes.
• Relatives told us staff kept them informed about their family members' wellbeing and significant events and were positive about the care provided with comments such as, "They [staff] take into consideration people's needs and treat them as individuals" and "The staff at Lavender court are wonderful. They do their best in sometimes difficult circumstances." Relatives expressed disappointment about the management of fire safety works in relation to refurbishment. This had resulted in people needing to relocate for several weeks prior to the lock-down in order for this to be rectified. Relatives had received a letter from the provider explaining why this was necessary for people's safety.
• Relatives had received some verbal information about covid-19 from the service. The provider had not arranged any written guidance for relatives about covid-19 information, how the service was responding, or

a copy of the visitor's policy and procedure. Relatives we spoke with said they would like more information about visiting agreements.
• Staff surveys about the impact of covid-19 were completed. Responses were generally positive about the level of information shared to promote safe working practices.
• Professionals involved with people's care were generally positive about care provided by staff and fed-back people appeared settled and happy in their environments. Communication from the service to professionals was inconsistent, ranging from detailed information sharing to failing to notify them about changes in people's needs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Staff we spoke were not familiar with the home's statement of purpose in relation to the service values however, they talked about providing people with personalised care and encouraged independence.
• There was no mandatory equality and diversity staff training however, staff new to care had received information about equality and diversity as part of their induction. Staff described how they respect people's differences and individual wishes and choices, with comments such as, "Understanding the choices they have today may be different to the ones tomorrow", "To respect everybody and treat them according to how they want to be treated, their likes and dislikes" and "I give residents at Lavender court choice to make their own decisions and time. People's preference can change, and we must always check."
• Staff asked if there would be any recognition from the provider for their efforts to work flexibly during the pandemic. The registered manager had fed this back to the provider and was awaiting a response.
• There was an equal opportunities policy and procedure in place for staff. Staff spoke positively about team collaboration with one another and support from the registered manager. Staff had not been individually risk assessed to consider whether they were of higher risk to covid-19. However, staff who were at higher risk had discussed this with the registered manager and were supported to shield at home. The registered manager agreed to complete staff risk assessments in line with government guidance to protect the workforce.
• Some staff had not received regular supervisions. Staff told us they were able to access the registered manager for one to one discussions to raise any issues. The registered manager explained supervisions had been impacted by the pandemic and staff absence. We saw improvement had been made since and the majority of staff had received a supervision since June 2020.

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 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify the Commission of specific events as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to make sure suitable staff were employed, which exposed people to potential risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Systems were not in place to demonstrate how the provider would ensure the duty of candour was fulfilled.

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 service failed to robustly assess the risks relating to the health safety and welfare of people. Health and safety risk assessments and checks for work activities and the environment were either not in place or robust enough to demonstrate risk was effectively managed. Safe medicines procedures were not always established or implemented which put people at risk of harm.

The enforcement action we took:

We served the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were either not in place or not operated effectively to investigate allegations or evidence of abuse. This exposed people to potential ongoing harm.

The enforcement action we took:

We served the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish or effectively operate systems or processes to ensure compliance with the requirements of the fundamental standards.

The enforcement action we took:

We served the provider with a warning notice.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The service did not ensure that staff were trained or competent to meet all of people's specific needs safely.

The enforcement action we took:

We served the provider with a warning notice.