Blue Sky Care Limited

Richmond Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

About the service
Richmond Lodge is residential care home providing personal care for up to five people with a learning disability. At the time of the inspection five people were living at the service. Accommodation is provided over two floors, accessed by stairs. A communal lounge and dining area are based on the ground floor.

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

Right Support:
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the providers own systems in the service did not always support this practice.

The provider did not make reasonable adjustments for people so they could be fully in discussions about how they were supported. Staff did not always support people to pursue their interests and to achieve their aspirations and goals, because they were not identified. People were not always engaged to take part in daily tasks and activities meaningful to them.

The provider did not always learn from incidents and how they might be avoided or reduced in the future. People's risk assessments were not detailed and did not provide guidance to staff on how to meet peoples' support need and reduce the risks.

People were supported to access specialist health and social care support in the community when this was required.

Right Care:
The provider did not accurately or fully assess risks people might face. People's support plans were not detailed and did not reflect their range of needs and did not always promote their wellbeing and enjoyment of life.

The service had enough appropriately skilled staff to meet people's needs and keep them safe during the day. However, there was only one night staff and there was a potential risk of people not having their needs met. We made a recommendation to the provider to review their dependency tool and staffing levels.

Staff knew how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right Culture:
The provider had not evaluated the quality of support provided to people, involving the person, their families and other professionals as appropriate. People and those important to them, told us they were not always involved in planning their care.

The provider's own governance systems and processes were not robust enough to identify areas where improvements were required.

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 19 December 2019).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to initial inquiries to determine whether to commence a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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

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

Enforcement and recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to providing safe care, person centred care, consent to care and the management of the service at this inspection.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Richmond Lodge

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 was carried out by one inspector and Expert by Experience on 16 August 2022 and one inspector on 22 August 2022. 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
Richmond Lodge 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. Richmond Lodge 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service. 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 (PIR). 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.

During the inspection
Not all people who use the service were able to tell us of their experiences verbally, so we observed their interactions with staff and spoke with one person using the service. We spoke with two people's relatives about their experience of the care provided. We spoke with seven members of staff including support workers, a team leader, the manager and the head of care. We reviewed a range of records. This included three people's care records and five medication records. We looked at four 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.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management;

- Risks to people and staff were not always identified, assessed and safely managed.
- People's risk assessments had not always helped them get the support they needed because they were not holistic, detailed and had not provided staff with enough guidance on how to reduce or manage known risks. For example, there were no risk assessments to support people at times when they informed staff they wanted to hurt themselves or at times when people had consumed excessive amount of alcohol.
- Some people lived with epilepsy and diabetes. The provider had implemented risk assessments around these health needs, however the identified measures to reduce the risks were not detailed enough and did not provide staff with enough guidance. For example, what to do during and after someone had a seizure. Staff were trained how to support people with diabetes or epilepsy.
- Some people were assessed as unable to access the community without staff support and were at risk of leaving the service without staff support at times when they were anxious or distressed. The provider had failed to produce a robust risk assessment and protocol, outlining what measures should be taken by staff upon discovering the person was not in the service or at times when the person went missing during an activity.
- People's risk assessments were not kept with their associated support plan making it difficult to understand the whole picture around how any risks should be mitigated or managed. This increased the risk staff might not support people correctly.
- Staff had not kept accurate and detailed records of people's support. We looked at daily logs for people who received one-to-one support and found the daily notes to be very limited. Some people's care records stated that staff had to assess people's mental state before they left the service, for example to go on a home visit or an activity, we found no records to confirm staff did that. This meant that people's support plans were not always followed.
- The safety and security of the service was not maintained. Staff told us they had concerns about safety, especially during evenings, because there were no lights in the car park area. The gate and front door to the service were left open for a long period of time during our inspection.

Learning lessons when things go wrong

- Following incidents involving people and staff, staff completed incident forms. A senior staff member then reviewed this to look for any trends or patterns. However, we found that the findings and outcomes from the review were not always reflected in people's support plans or risk assessments.
- The support plans showed that a review had been completed, but there had been no changes or amendments made to reflect the latest incidents. For example, following a recent incident where one person used a gardening tool as weapon against a staff member, a note was added to their support plan to reflect this incident, but the risk assessments was not updated. Additional measures on what could be done

to avoid this incident from happening again were not considered or added to the risk assessment.

Using medicines safely

● People's medicine was not managed safely.

● People's medicine administration record charts (MAR charts) were not appropriately completed. We saw that the MAR charts were not signed by the person who booked the medicine in, to confirm they checked the medicine received was correct before it was given to people. Following our feedback on day one, the provider had investigated this issue and on day two of our inspection we saw the MAR charts were reviewed and signed for by staff.

● We noticed two occasions within one day where the MAR chart was not signed to confirm the medicine was given to one person. We checked this person's medicine stock and found the stock to be more than what it was supposed to be. This suggested that one person was not given their prescribed medicine which was used to treat their epilepsy. Missing this particular medicine could trigger a seizure.

● We also found that another medicine, used to treat hyperactivity, had not tallied with the recorded stock. This showed that one person had not received their medicine as prescribed, which could have had an impact on their wellbeing. This also meant that staff had not carried accurate daily stock checks in line with best practice guidance regarding controlled drugs.

● Some people had prescribed "when required" (PRN) medicine. We found the provider had failed to implement person-centred support plans containing enough information to support staff to administer PRN medicines as well as clear and concise PRN protocol outlining when this medicine should be given.

● We checked the medicine room temperature record and we found that on multiple occasion the room temperature exceeded the recommended maximum level for safe storage of the medicines. Temperatures above the recommended range can physically change medicine and affect their potency (how well they work) which could be harmful to people's health. We saw no evidence staff took any actions to reduce the temperature of the medicine room.

The provider failed to manage and assess potential risks to people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks to the environment such as fire risk assessment or legionella risk assessment were carried out by external professionals to ensure the premises were safe.

● Staff had carried out regular fire safety checks such as weekly alarm checks and six-monthly fire drills. Staff had checked the hot water temperature before people used the bath or showers to ensure people were not at risk of scalding.

Staffing and recruitment

● The service had enough staff during the day, including for one-to-one support for people to take part in activities. However, there was only one night staff and there was a potential risk of people not having their needs met.

● Most staff told us they felt the staffing levels were adequate throughout the day, however they did not feel there were enough staff during the night. This was due to two people who had epilepsy and others could present with distressed behaviours. When a person had a seizure, staff had to stay with them, this meant there was no one else available to support other people during the night.

● We raised this issue with the manager and the provider who told us there had been no incidents during the night and they had assessed night staff levels as safe. The manager told us they also operated an on-call system, which meant a senior member of staff was on a standby during the night and would be required to support night staff should this be needed.

● Staff recruitment and induction training processes promoted safety, including those for agency staff. The

provider completed checks on the suitability of potential staff and agency staff. This included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

We recommend the provider review their dependency tools and staffing levels.

Systems and processes to safeguard people from the risk of abuse
● People and staff were not always kept safe from avoidable harm.
● People and staff had suffered harm and injuries due to the incidents caused by people's distressed behaviours that resulted in physical violence. Staff had not used physical restraints because they were only trained to utilise breakaway and distraction techniques, however these were not always effective.
● Staff told us that at times when people displayed distressed behaviours, they had to do their best to keep other people safe. Staff did that by asking them to move to a safe place, such as their bedrooms, so they were not at risk of harm. Staff told us they had to, on a few occasions, request Police assistance due to the severity of the behaviours and to prevent a person from hurting themselves, other people or staff.
● We only spoke with one person living at the service who told us they felt safe at the service. When we asked one person if they felt safe, they told us they did, when we asked why they told us, "protection from staff and they go out with me."
● We spoke with people's relatives who told us they felt their relatives were safe at the service. One relative told us, "[name] seems to be quite happy and settled at the service, [person] gets the support they need."
● Throughout our observations we saw that people were relaxed and staff had a positive interaction with them.
● Staff had training on how to recognise and report abuse and knew how to apply it. Safeguarding processes were discussed during staff's supervisions and there was information about the local safeguarding team displayed in some areas of the service.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. An outbuilding was used for storing food items as well as gardening tools. The outbuilding was not adapted enough for the safe storage of food and was not hygienic.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider supported visits for people living in the home in line with current guidance.

Inadequate

Is the service effective?

Our findings

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

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

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

- People's care and support plans did not reflect current evidence-based guidance, standards and practice. People's support plans had not holistically assessed their needs. For example, people's religious beliefs and sexuality were not clearly recorded. The lack of information could impact the staff's ability to provide effective person-centred care to meet people's individual needs.
- Some people could become anxious and show signs of distressed behaviours. People did have support plans called "Positive Behaviour Plans", however these plans were not holistic and had not included a functional assessment of behaviours, which was not in line with best practice. There was no detailed guidance for staff, explaining what interventions they should take to change the behaviour pro-actively (before it reached a crisis point), or if that failed, how to manage behaviour reactively (when the person reached crisis point).
- People's assessments and support plans did not include details and methods of communication needs. Some people had difficulty communicating with others and the provider had failed to ensured people had access to the information in formats they could understand. For example, there were no evidence pictorial aids or social stories were in place, which would help people to make day to day decisions.
- The provider had not assessed and considered the longer-term aspirations, goals and outcomes of each person. People's support plans had not set out pathways to future goals, for example teaching people new skills to promote and enhance their independence. The provider had not collected any data about how people were progressing or struggling, with their hobbies, interests or daily living achievements.

Supporting people to live healthier lives, access healthcare services and support

- Information about people's specific health needs was not always personalised to them and had not provided staff with enough guidance.
- People's health action plans had not set out what their health needs were and how they were being supported with. Information about people's medicines, for example the reason the medicine was prescribed and how it should be administered in people's preferred way was not recorded. Some care plans had NHS information leaflets, for example about epilepsy, however this information was not specific to the person and only provided staff with generic information. This increased a risk of staff not supporting people correctly.
- People's support plans had not included details about how staff should support them with health-related appointments. Some people found it difficult to access community health services or interventions from health professionals due to their anxieties. There were no care plans to describe how else people should be supported. For example, requesting a home visit or asking a family member to support them to attend their

health appointments. This increased the risk of people not having their health needs met.
● People were not well supported to manage risks with their oral care. Some people could present with behaviours that increased their risk of poor dental health. There were no oral care assessments to assess people's dental risks.
● Some people living at the service had autism and the provider had not considered if people had sensory needs or any specific routines. Many people with autism can find some things such as certain lighting, sounds, smells, textures and tastes overwhelming. These needs had not been assessed to determine if people needed additional support. Guidance for staff to support people to have a good day and a good week had not been completed, despite some people requiring a routine to their days and weeks.

The provider did not ensure that care plans fully identified or met people's needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● For people the provider assessed as lacking mental capacity to make certain decisions, the provider did not have an appropriately recorded assessments and best interest decisions.
● People had various mental capacity assessments completed to establish whether they had the capacity to make specific decision about aspects of their lives. However, the MCA were not completed in line with the best practice and the Act. For example, where people were assessed as not having the capacity, the assessments were completed based on the assumption that people lacked the capacity. There was no evidence to show how people were involved in the assessment process, what communication aids or prompts were used to enable people to gather better understanding about decisions being made.
● Many decisions affecting people had not been considered and assessed. For example, decisions about the amount of support people received, COVID-19 vaccination or using an audio monitoring system throughout the night were not completed. This meant the provider had not considered whether these decisions were made in person's best interest.
● MCA records did not appropriately document how people's representatives were consulted. All MCA's we looked at stated family and social worker input had been considered and they agreed with the decisions. However, they did not provide any information about when and how people were consulted or any specific information about their views. The best interest documents were also unsigned by families or other professionals involved in decision making and only signed by the manager.

Effective systems were not operated to ensure the service worked in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people required DoLS applications, these were completed and submitted to the local authority. Where DoLS applications were pending approval from the local authority, we saw evidence of the manager following this up.

Supporting people to eat and drink enough to maintain a balanced diet
● People had a choice of food and people's menus were planned in advance. We did not see any evidence of how people were involved with choosing their meals. The menus were not designed in an easy to read format, such as using pictures or photographs of food items for people who had communication difficulties.
● People's care plans had not always detailed the support they required regarding their eating and drinking requirements and how staff should encourage them to eat a balanced diet. For example, one person was at risk of malnutrition and required a fortified diet. The care plan had not identified how to fortify their meals.
● Some people were able to cook their own meals with staff supervision, whilst others required support from staff. We observed one person was frying some bacon for their breakfast whilst staff were stood next to them providing verbal directions.

Adapting service, design, decoration to meet people's needs
● The environment was not always homely and stimulating. The main lounge was recently redecorated, however there were stains on the walls and ceilings from a water leak, which made the room look unpleasant. There was a lot of staff information and posters stored on the wall and on top of a cupboard in the dining room area which made the area look unhomely.
● Peoples bathrooms required new grouting and sealing around shower enclosures. This meant that effective cleaning was not carried out due to poorly maintained facilities.
● The garden was spacious however was unkept and the fence around the perimeter of the service was leaning towards one side. There was a risk it could fall over and potentially hurt someone. The provider told us they had plans in place to erect new fence and to carry out additional work to the trees around the service.
● People's bedrooms were personalised, and people were able to have things they wanted to have. Some people had various gaming consoles, TV's and other items important to them. People were able to decorate their own rooms.

Staff support: induction, training, skills and experience
● Staff had recently received training about managing distressed behaviours. This type of training equips staff with the knowledge on how to remove themselves away if a person attempts to hold or harm them. Staff told us they found this training helpful and were able to utilise it in practice.
● Staff had received relevant training in evidence-based practice. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs and communication.
● Staff received support in the form of continual supervision, appraisal and recognition of good practice. We looked at staff supervision records and found them to be detailed and focused on many aspects of the service and support people received.

Staff working with other agencies to provide consistent, effective, timely care
● People received annual health checks with their GP and some people were supported to access other healthcare professionals such as opticians as and when this was needed.

● People were referred to health care professionals to support their wellbeing and help them to live healthier lives. When people experienced periods of distress the provider sought support from the Intensive Community Assessment and Treatment team who could offer specialist recommendations and interventions to reduce unnecessary admission to inpatient services.
● We saw referrals were made to a dietician where required.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The providers own internal governance arrangements did not ensure the safety and quality of the service. The provider had completed a range of quality audits; however, these were not effective and failed to recognise shortfalls and poor quality of risk assessments and support plans. Quality assurance systems and processes did not identify issues we found at this inspection.
- Despite medicine audits being carried out regularly by staff, the provider had failed to ensure these checks were undertaken effectively to identify shortfalls, errors and omissions. The audits were not robust and had failed to identify the concerns relating to the medicine management we found during our inspection. For example, medicine audits did not identify issues such as a lack of PRN protocols, incomplete MAR charts or failures to ensure medicines stock were accurately recorded.
- Staff did not keep detailed records about level of support and care provided to people or details of undertaken activities. For example, some entries read as, "[name] sat with staff looking at magazines", or "[name] helped staff prepare dinner." This information was insufficient to determine whether the activities were meaningful to people and whether people enjoyed doing them. There was no regular auditing of these records and no processes for monitoring whether people achieved positive outcomes and were progressing.
- Some records about people's care were not kept securely. During the inspection we saw an office was left open and unattended. The cabinets were not locked, and they contained some confidential information.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People's hobbies, interests, daily living needs and support were not prioritised, and people's support plans were not kept up to date. We saw no evidence showing people's support plans reflected planning for the future and a progression towards longer-term aspirations as well as providing continuity over their life's journey.
- The providers own systems did not always evidence how people were supported to express and review how they wanted their care to be provided. We saw no evidence to demonstrate how people were involved in the development of their support plans.
- The provider had not taken any steps to comply with the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.
- The provider was not meeting legislation, guidance and best practice in relation to supporting people with learning disabilities and autistic people. This included not meeting Right support, Right care, Right culture,

and National Institute for Clinical Guidance (NICE) for supporting people with learning disability and autistic people.

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

● We saw people were given a choice in what they would like to eat, and what activities they would like to do. However, people were not always engaged and involved with day to day tasks, for example we saw that when the afternoon meal was being prepared staff had not asked anyone if they would like to help. We also saw staff hanging out the washing, again this task was completed only by staff.

● The provider had failed to implement effective systems and processes to ensure people's support plans and risk assessments were reviewed and updated regularly. This was because reviews did not take in to account recent events that affected people, such as incidents or specific activities people participated in. We saw no evidence people's relatives or those acting on their behalf were involved in the review of their care.

The provider failed to have oversight at the service, to ensure care was high quality and improvements were made. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual gave assurances that action would be taken to improve oversight of the service. We will review what action has been taken at our next inspection.

● Statutory notifications were submitted as required. Statutory notifications are important because they inform us about notifiable events and help us to monitor the services we regulate.

● Staff felt able to raise concerns with managers without fear of what might happen as a result.

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 was aware of their responsibility to act openly and honestly when things went wrong.

● The provider had informed people's relatives or these acting on their behalf when things went wrong. For example, following serious incidents. A relative told us, "The best thing is the way they contact me with any problems or issues."

Working in partnership with others

● People were referred to health professionals in a timely way when this was needed. One professional told us, "Management have been responsive to any issue raised or questions along with implementing our requests", and "I feel that the induvial I am working with needs are being met by the service, the team are willing to learn and adapt to different ways of working when asked."

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's capacity was assessed in line with the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people were supported in a person centred way, in line with best practice guidance.

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and manage risks placing people, staff and other at risk of avoidable harm.

The enforcement action we took:

We issued 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 failed to ensure systems for monitoring the quality of the service were robust and in place. This placed people at risk of harm.

The enforcement action we took:

We issued a Warning Notice.