Kisimul Group Limited

Breagha House

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

About the service
Breagha House is a residential care home which provides accommodation and personal care for young adults whom are living with a learning disability and/or autism. The service can support up to ten people. At the time of our inspection, ten people were living there.

People's experience of using this service and what we found
People were not kept safe from the risk of abuse. Staff did not always feel confident to raise concerns or did not feel their concerns would be taken seriously. People were at risk from neglectful and abusive care practices.

Risks to people's health, safety and welfare had not been adequately assessed and mitigated. The provider had not ensured people lived in a safe environment. There were not enough staff to keep people safe. People's medicines were not managed safely.

We were not assured that the provider had good infection control practices. The provider did not learn lessons when things went wrong.

People's needs and choices were not assessed in line with current legislation and guidance, or in ways that helped to prevent discrimination. People were not supported to communicate in ways which were meaningful to them.

People were at risk of receiving support from staff who were not trained to meet their needs. People were at risk of being offered unhealthy and unsuitable food choices, and at risk of not being able to participate in their own meal planning.

People were not always supported to access external health appointments in a timely way. Consent to care was not sought in line with legal requirements.

The service was not well-led. People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks were in place. The provider did not ensure staff followed policies and procedures for the delivery of safe care.

The provider had not consistently notified CQC of significant events as they are legally required to do. Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements.

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 guidance CQC follows 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. People's care was not person-centred and did not promote their dignity and rights. Due to the range of safeguarding concerns being investigated by the local authority and police, we felt there was a risk some staff did not demonstrate attitudes and values that promoted compassionate and inclusive care.

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 14 September 2019).

Why we inspected
We received concerns in relation to staffing levels, medicines management, safeguarding issues, restrictive care practices, and poor management practices. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

The inspection was also prompted in part by notification of a specific incident, following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Breagha House 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 regulations 9, 11, 12, 13, 14, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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**

Breagha 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.

Inspection team
This inspection was carried out by two inspectors

Service and service type
Breagha 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. At the time of our inspection the registered manager was not available.

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 about 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

During the inspection we spoke with two people who used the service and observed how care and support was given generally. We spoke with three staff, two interim managers, the area manager, and the provider's director of adult services. We looked at a range of records including five people's care records and how medicines were managed for people. We also looked at staff training, and the provider's quality auditing system. During the inspection visit we asked the provider to give us additional evidence about how the service was managed. They sent most of the information we requested but did not send some evidence to us.

After the inspection
We continued to seek clarification from the provider regarding the evidence we had. We sought feedback from the local authority safeguarding staff, and quality monitoring team. We also spoke with staff from advocacy services who were involved in supporting people.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not kept safe from the risk of abuse. All ten people living at the service were being supported by the local authority in relation to allegations of abuse.
- Concerns raised by staff were not acted on by the registered manager or provider where people were at risk of abuse. Staff did not always feel confident to raise concerns or did not feel their concerns would be taken seriously. Although staff received training in how to recognise and report potential or actual abuse, they did not always put this training into practice.
- A person requiring one to one support was found to have eaten a non-food item. There was no evidence to show this had been responded to appropriately by registered persons.
- We found a number of incidents recorded by staff that had not been reported to the local authority or CQC. The provider's system to check on safeguarding processes was inadequate and did not identify the failings we found on inspection. This left people at risk of continued neglectful and abusive care practices.

This was a breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people's health, safety and welfare had not been adequately assessed and mitigated. Risk assessments were in place, however they did not provide enough information on how to mitigate those risks.
- People who had a diagnosis of epilepsy did not have effective and detailed risk assessments in place. There was no information how to support people with post-seizure recovery or what to do to maintain their dignity during a seizure. There was one incident where staff did not follow the person's care plan and did not seek medical advice until the day after the seizure. This put the person at risk of harm from the potential damage an unexpected seizure could cause.
- People who needed support with continence required staff to prompt them. There was no evidence in daily care notes this happened, and staff confirmed this was not recorded. The provider could not assure themselves people were being supported to manage their continence appropriately. This put people at risk of developing health issues with skin integrity and other infections.

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

- The provider had not ensured people lived in a safe environment. Risks associated with the premises and equipment were not managed through regular safety checks and maintenance at the home.
- For example, at the time of our inspection the provider could not assure us fire safety systems were

checked regularly to ensure they were fit for purpose. Following our inspection, the provider found the fire check records in an archive. However, this meant the provider could not assure themselves that these essential checks were taking place at the time of our inspection. There were no fire evacuation procedures clearly visible near the front door to the service. There was no visitors sign in and out book. This meant staff did not know who was in the building in the event of emergency evacuation.

● Where people were known to eat non-food items, known risks were not mitigated. One person's wardrobe door was broken on 10 February 2021, and staff assured us this would be fixed promptly. It had still not been fixed by 1 March 2021. This left items accessible to the person. Staff removed items when we pointed this out. However, it was clear from the person's risk assessment their clothing storage areas should be kept locked at all times. The person was at risk of accessing non-food items to eat, and potential harm from this.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff to keep people safe and provide the support they were assessed as needing. Most people living at Breagha House were assessed as needing one-to-one support at various times of the day to ensure their safety. Some people needed two staff to support them to go out for day-to-day activities. On the first day of our inspection there were only eight staff on shift supporting 10 people.

● One person had raised concerns they did not always get their one-to-one staff support. Staff also confirmed there were times when either there were not enough of them on each shift, and that there were times when people did not have the one-to-one support needed.

● This meant there were times when people did not receive the support they needed, and were at risk from unsafe care.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us the provider undertook pre-employment checks to help ensure prospective staff were suitable to care for people. Additional evidence for the provider confirmed this. The provider ensured staff were of good character and were fit to carry out their work.

Using medicines safely

● People's medicines were not managed safely and people were at risk of not receiving their medicines as prescribed.

● There was no clear guidance for staff on when to administer medicines that were prescribed on an 'as required' (PRN) basis. Some PRN protocols were in place but did not give adequate information on when the medication would be needed. For example, when pain relief was administered, staff did not record what pain the person had described and did not record if the pain relief had been effective. Therefore, it was not possible to review whether the medication was effective.

● There was no system in place to ensure that medicines were checked each month when the new medicine cycle started. Records about stocks of medicines were inaccurate and could not show medicines were accounted for, or had been given as prescribed. During the inspection we found that the actual number of remaining medicines did not tally with what should have been in stock. This meant that at some point the administration of medicine was not administered. This put people at risk of not receiving their prescribed medicines.

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

● We were not assured that the provider was preventing visitors from catching and spreading infections. There was no clear guidance for how visits should safely take place. Whilst visitors were screened for coronavirus symptoms and their temperatures were checked on arrival to the service, this was not consistently done in accordance with national guidance.

● The risk of coronavirus to people and staff with underlying health conditions had not been assessed. People readmitted to the service following discharge from hospital had not then undergone any period of isolation. This put people at risk of infection.

● Areas of the service were not clean, or not able to be cleaned effectively. For example, there was damage to areas of door frames and kitchen worktops. In the laundry, clean items were stored next to soiled laundry. This presented a risk of cross-contamination and infection.

● Staff did not keep records of what cleaning had been carried out. There was no evidence more frequent cleaning was carried out during the coronavirus pandemic. For example, on high touch points in the service where the risk of cross-contamination would be increased, such as door handles. The lack of cleaning records meant the provider was not able to assure themselves that cleaning was taking place to the standards they required.

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

Learning lessons when things go wrong

● Accidents and incidents were not monitored to identify trends and to prevent reoccurrences. Individual incidents were treated as isolated occurrences, and there were missed opportunities to prevent further incidents and improve people's care. The provider did not learn from incidents.

● Following our inspection the provider took action to improve their processes for analysing incidents to determine how to improve the quality of care.

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

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 now 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

- People's needs and choices were not assessed in line with current legislation and guidance, or in ways that helped to prevent discrimination. For example, the provider did not nationally recognised best practice guidance to identify and monitor people in relation to pain management. Assessment of people's needs in relation to protected characteristics under the Equality Act were not considered in people's care plans. For people with a learning disability or autism, national guidance on person centred care and restrictive care practices were not followed.
- People were not supported to communicate in ways which were meaningful to them. There was no evidence staff were using assistive communication where people were assessed as needing this support. This put people at risk of not being able to communicate their needs and wishes effectively.
- People who had specific sensory needs did not have these met. For example, one person's external health professional advice detailed how their sensory needs should be met by staff. This information was not transferred across to the person's care plan, and staff did not know what their needs were or how to meet them. This put the person at risk of distress and anxiety.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The provider expected staff to undertake a range of mandatory training courses, including first aid, safeguarding, medicines competency and positive behaviour support. Not all staff were up to date with this training. For example, 15 out of 31 staff had not had their annual refresher training in positive behaviour support, including the use of restrictive care practices. People were at risk of receiving support from staff who were not trained to meet their needs.
- Staff had training on effective communication, including the use of PECS and signing. PECS is a visual communication system for people who use non-verbal communication. However, there was no evidence staff routinely used this type of communication to support people to express themselves.
- Daily handovers between staff teams were not done effectively. The provider was not able to identify whether key information about people's daily care was being shared with staff. This meant staff coming on shift were not consistently aware of how people had been supported by the previous shift's staff. We spoke with the provider about this, and they immediately put systems in place to address this.

This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● There was no specific guidance for staff on how to prepare meals for people, and there was no evidence of consistent menu planning. People's care plans in relation to food and drink did not have sufficient information about how to meet their dietary needs and preferences. For example, one person said they needed a, "Varied and healthy diet." Another person's care plan stated they needed to be given pictures and health information about meal options to enable them to make good dietary choices.

● There was no evidence that staff were given guidance and support with understanding how to plan healthy balanced diet options for people. Staff confirmed they did not use pictures or other communication support aids to help people be involved in menu planning and choosing food options. People were at risk of being offered unhealthy and unsuitable food choices, and at risk of not being able to participate in their own meal planning.

● For people who needed weight or diet monitoring, there was no plan in place to enable staff to effectively do this. For example, one person's care plan said they were on a, "Healthy diet due to increased weight gain." The registered manager and provider had not created a care plan to specify how the person should be supported to reduce weight or how to monitor this. There was no guidance for staff on how to support the person with a healthy diet and how to monitor this. This put the person at risk of developing health conditions associated with weight increase and unhealthy diet.

This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● The provider had not consistently ensured the environment was suitable for people's needs.

● There was no plan in place to ensure people's sensory needs were met within the communal areas of the service environment. We found the main communal areas of Breagha House could be busy and noisy, due to both the layout of the kitchen and dining areas, and due to the number of people and staff present. This created an environment which was potentially overstimulating or promoted anxiety for some people. For example, two people needed quieter environments that were not overstimulating for them. This was confirmed by staff and documented in their care plans.

● The provider had not fully considered the compatibility of people living together at Breagha House. This meant there were people living there who inadvertently behaved in ways which other people found difficult to cope with. This put people's mental health and well-being at risk.

● The provider is aware of these concerns and is taking steps to reduce the number of people living at Breagha House. The provider is also considering how various areas of the building can be used creatively to reduce the risk of environmental factors that make people feel unhappy or unsafe.

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

● People were encouraged to make choices about decorating their personal space, and their bedrooms were personalised.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were not always supported to access external health appointments in a timely way. For example, one person's care plan for oral health said they had a full dental check-up every three months, and staff should monitor for indicators of any continued pain following a tooth extraction in July 2016. There was no evidence in the person's records they were supported to have three-monthly check-ups, and no records of

staff monitoring pain in relation to oral care. This put the person at risk of pain and poor oral hygiene.
● Another person had several incidents where they swallowed inappropriate non-food items. Neither staff nor the registered manager sought medical support for the person following each incident. This put the person at risk of becoming ill due to ingesting items that were not suitable to eat.
● Staff did not have any tools or guidance to help them assess people's pain or discomfort. This was particularly important for people who could not reliably communicate this using words. This meant staff could not consistently identify when people were in pain, and people were at risk of not receiving appropriate health services.

This was a breach of regulation 12 (Safe care and treatment) 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 , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Consent to care was not sought in line with legal requirements. This put people at risk of having their rights breached. Although people were asked about consent on a day-to day basis in relation to personal care support and activities, staff did not consistently use communication aids to ensure people knew what choices they were being offered.
● Assessments of people's capacity for specific decisions did not demonstrate how information about each decision was given. People who needed additional aids to help them understand choices were not given this support. This meant people were not able to participate in making decisions about their own care in a meaningful way.
● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people. Conditions associated with people's DoLS authorisations were not reviewed regularly to ensure they met the principles of the MCA.
● For people who were assessed as having restrictions in their care, it was not clear from records who was consulted or what their views were. For example, two people had restrictions around food choices. The provider could not demonstrate why it was necessary to have the restrictions in place or that they were in people's best interests.
● In relation to the use of physical restraint, guidance for staff did not consistently document what specific types of intervention was assessed as suitable for each person. Three people's positive behaviour support plans referred only to the use of 'blocking' where staff place themselves between the person and a hard surface, and 'breakaway techniques.' However, the people's care plans also referred to 'control measures,' not specifying what these were and when they could be used. This put people at risk of harm from the use of unsafe or unlawful physical restraint. It also put staff at risk of being injured.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks were in place. For example, in October 2020 the provider's internal compliance team identified a number of concerns about medicines management. On our inspection, there were still concerns about the safety of medicines management.
- The provider had not ensured staff followed the policy on restrictive intervention. This policy stated the care environment should provide predictable access to preferred items and activities and avoid excess levels of environmental stimulation. People who were assessed as needing sensory items and structured activities to reduce anxiety did not consistently receive this support. This resulted in an increase in people's distress and anxiety behaviours.
- The provider had not ensured staff followed policy and procedure in relation to reporting allegations of abuse. Investigations by the local authority and by the provider identified a number of incidents which should have been reported and investigated appropriately. This had not happened, and left people at risk of further potential abuse and harm.
- From our analysis of the provider's training evidence, a number of staff were out of date with a range of training. The provider was not able to demonstrate how they supported staff to deliver high quality specialist care for people with a learning disability and/or autistic people.

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

- The provider had not consistently notified CQC of significant events as they are legally required to do. For example, in August 2020, one person's care records documented they had hit out at another person living at the service. Registered persons are required to notify CQC about and abuse or allegation of abuse in relation to a person, and we did not have a notification for this. This meant the provider was not informing us about events that occurred in the service which assist us to monitor the quality of care.

This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care

- There was no evidence that the registered manager or provider gathered and used information from the

daily running of the service such as care plan reviews and accident and incident data to learn and improve the care provided to people.

● The provider did not have a system in place to support the registered manager and staff to analyse risk information in relation to people's care. This was particularly in relation to incidents and any episodes of behaviour that was of concern. The registered manager and provider did not have a clear overview of risks, themes and trends of incidents. This meant opportunities to improve the quality of care for people were missed.

● Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements.

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

● The provider was working with the local authority and commissioners to identify where their systems had failed. The provider had developed a detailed action plan to improve all aspects of the service. We could see where action was being taken, and the positive impact this was having on people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider did not ensure that people were as fully involved as they could be in designing their care and support. People's care plans and associated documents did not demonstrate that people and their relatives had been consistently involved in developing and reviewing care.

● Some staff did not feel confident their concerns or ideas for improving care would be acted on. For example, they told local authority safeguarding staff that staffing levels were regularly unsafe, and their concerns were not listened to.

● The provider did not always recognise when people's needs changed. They did not always make appropriate referrals to health and social care professionals promptly to address this. This meant people did not get the care they needed.

● People who had been assessed by external professionals did not always have the professional recommendations put into practice. For example, one person should have had three-monthly dental appointments. There were no records of this, and staff could not confirm whether this happened.

● Record keeping did not consistently refer to people by the gender pronouns they used. For example, in one person's care plan, they were referred to by the wrong gender. This showed a lack of consideration for accurate record keeping, and for the person's preferred pronouns.

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 provider had not consistently notified CQC of significant events as they are legally required to do. This meant the provider was not informing us about events that occurred in the service which assist CQC to monitor the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was no specific guidance for staff on how to prepare meals for people, and there was no evidence of consistent menu planning. People's care plans in relation to food and drink did not have sufficient information about how to meet their dietary needs and preferences. For people who needed weight or diet monitoring, there was no plan in place to enable staff to effectively do this.

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 People's needs and choices were not assessed in line with current legislation and guidance, or in ways that helped to prevent discrimination. People were not supported to communicate in ways which were meaningful to them. People who had specific sensory needs did not have these met.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care was not sought in line with legal requirements. Restrictive care practices were not done in accordance with legal requirements and national best practice guidance.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, safety and welfare had not been adequately assessed and mitigated. People's medicines were not managed safely. We were not assured that the provider had good infection control practices. People were not consistently supported to have a balanced diet. The provider had not consistently ensured the environment was suitable for people's needs. People were not always supported to access external health appointments in a timely way.

The enforcement action we took:

We have imposed conditions on the provider's 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 People were not kept safe from the risk of abuse. Concerns raised by staff were not acted on by the registered manager or provider where people were at risk of abuse. Staff did not always feel confident to raise concerns, or did not feel their concerns would be taken seriously.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured people lived in a safe environment. Risks associated with the premises and equipment were not managed through regular safety checks and maintenance at the home.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks were in place. The provider was not able to demonstrate how they supported staff to deliver high quality specialist care for people with a learning disability and/or autistic people. Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements. Individual incidents were treated as isolated occurrences, and the provider did not look for patterns or a wider context. There were missed opportunities to prevent further incidents and improve people's care.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to keep people safe and provide the support they were assessed as needing. People were at risk of receiving support from staff who were not trained to meet their needs.

The enforcement action we took:

We have imposed conditions on the provider's registration.