White Cliffs Lodge Limited

White Cliffs Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
White Cliffs Lodge is a care home providing accommodation and personal care to up to maximum 15 people. The service provides support to people who need support with their mental health and or people with a learning disability and autistic people. At the time of our inspection there were 13 people using the service.

The service was separated into two houses, White Cliffs Lodge and White Cliffs Court. White Cliffs Lodge supported 6 people. White Cliffs Court supported 7 people in their own self-contained flats.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
Staff did not always support people to achieve their aspirations and goals. Staff were not always able to support people to take part in activities and pursue their interests in their local area due to the availability of drivers. People were not 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 policies and systems in the service did not always support this practice. For example, best interest meetings had not always been carried out. However, following inspection the provider carried out best interest meetings with family members where a need was identified.

Right Care
Staff had not always protected people's privacy and dignity. Not all people had curtains or blinds at their windows. Staff had not consistently applied their safeguarding training as incidents were not always recorded or reported in line with guidance, not all staff had completed their safeguarding training. People were not always supported in line with their care and support plans, for example, some people were at risk of choking and staff had not always followed guidance, resulting in choking episodes. We observed kind and caring interactions between people and staff during inspection

Right Culture
The culture of the service did not always enable staff to continuously learn and improve. For example, lessons learned from incidents were not always analysed and shared with staff. The service had recently introduced the use of advocates to support people. The service was aware of some of the concerns we identified on inspection and had already started to implement a service development plan to address the issues.

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 24 January 2019).

Why we inspected
We received concerns in relation to the management of people's specific health risks and their safety. As a result, we undertook a comprehensive 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 COVID-19 and other infection outbreaks effectively.

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 White cliffs lodge on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people's safety, how the service manages and mitigates risks to people and the overall governance and running of the service, person centred care and the skills and competencies of staff.

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

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

CareQuality Commission

White Cliffs 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.

Inspection team
The inspection was carried out by 2 inspectors

Service and service type
White cliffs 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. White cliffs 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in the post 2 weeks at the time of our inspection and was in the process of submitting their application to register.

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. We used the information the provider sent us in the provider information return

(PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service and two relatives about their experience of the care provided. We spoke with 8 staff including the locality manager, home manager, deputy manager, senior support staff and support staff.

We reviewed a range of records. This included 5 people's care records including medicine records. We looked at 2 staff files in relation to recruitment. 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; Learning lessons when things go wrong

- People were not always kept safe from the risk of harm. The provider had not kept people safe through formal and informal sharing of information about risks. People's specific health needs were not always well managed.
- People who were at risk of choking were not always supported in line with their guidance. One person had a number of incidents where they had choked on their food and needed first aid. During 1 incident, it was recorded the staff member was not giving the person 1-1 attention and they choked on their food and needed first aid. Following inspection, the person had been re-assessed by the speech and language therapy team (SALT) to ensure they were getting the correct support from staff.
- People who had been prescribed physiotherapy stretches were not being supported by staff to complete these. For example, 1 person needed a form of chest physio by using a specialised vibrating cushion 3 times a day to prevent chest infections. This support had not been recorded in daily notes and staff told us they were not supporting with physio as prescribed.
- People had some guidance in their support plans for how to support them if they became upset, anxious and distressed. However, these did not always contain enough detail to ensure staff supported people safely.
- Environmental risks had not been consistently managed. For example, we found window restrictors in 1 room to be unlocked. Window restrictors are used to keep people safe from falls. There were a large number of used cigarette ends on the ground in the garden which people would regularly access.
- There was no robust system in place to analyse incidents and ensure there was any actions or learning to be considered. The home manager was aware the system for recording incidents and accidents was not robust and was in the process of implementing a new system.
- Incidents were not always recorded, when they were recorded, they were filed away into people's support plans before being reviewed to ensure any actions could be taken.

The provider had failed to assess the risks to the health and safety of people or do all that is reasonably practicable to mitigate risks. This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People were not always kept safe from avoidable harm. We identified incidents that had not been recorded or reported in line with the provider's guidance. For example, an incident had occurred between two people had not been reported to the local safeguarding team.
- Another incident had been recorded in the person's notes that they were found to have blood and a bruise on their nose, this had not been reported on an incident form and not referred to the local safeguarding

team.
● Staff told us 1 person did not always feel safe living at the service. Staff explained how the person would keep their door closed or take themselves next door because they did not always feel comfortable being around another person, specifically if the other person was distressed.
● Some staff member's safeguarding training had expired. The home manager was aware of this and had issued letters, in line with their policy, to the staff to ensure they completed this training by a certain date.

The provider had failed to ensure systems and processes were established and operating effectively to prevent the abuse of service users. This was a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicine administrations were not always recorded in line with guidance. For example, some people needed as required medicines to support them if they were anxious or distressed. The administration had been documented on the Medication Administration Record (MAR) however details on whether the medicine had the desired affect was not documented. One person was prescribed more than 1 as required medicines for when they were distressed. It was not always detailed why more than 1 of the as required medicines were administered. This is an area for improvement.
● Staff who administered medicines had completed relevant training.
● Temperatures were recorded to ensure medicines were kept in a location that did not exceed the recommended temperatures for storing the medicines. If it was identified that storage was exceeding the temperatures, action was taken such as adding an ice pack to the cabinet.

Staffing and recruitment
● The provider had failed to ensure there were enough competent, skilled, and trained staff deployed to support people. The number of skilled and competent staff did not always match the needs of people using the service. For example, staff had not had training to support a person's physiotherapy exercises.
● The service did not consistently deploy enough trained staff to support people. For example, not all staff had completed safeguarding training. We identified staff had not always recorded incidents or reported incidents to the manager that were reportable to the local safeguarding team.
● The provider failed to ensure there were enough staff deployed, who were able to drive, regularly on shift.
The provider had failed to ensure there were enough skilled and competent staff in the service. This is a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Safe recruitment processes were followed. The provider ensured pre-employment checks were completed before staff began working at the service. These checks included a current Disclosure and Barring Service check (DBS). DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

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 assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● 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
People were supported to have regular visits with people who were important to them.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People did not always have support plans that set out their current needs. For example, a person's care plan detailed physical interventions could be used to support them as a last report during periods of distress. Staff and the home manager confirmed that the service do not use any physical interventions and this was in place at the person's last service.
● The home manager and staff identified when people's needs had changed, however, care plans did not always reflect this. For example, a person's care plan detailed they were prescribed medicines for constipation. Staff told us this person no longer needed this medicine after a review with their GP. The care and support plan had not been updated to reflect this.
● Recognised tools were used to deliver care in line with standards and guidance. For example, people who were at risk of skin break down had a completed Waterlow tool in place. The Waterlow tool assess the risk of the person developing a pressure ulcer.

Staff support: induction, training, skills and experience
● Staff did not always have the skills and experience to support people. Some staff had completed dysphagia training, however, there had been a number of choking incidents. For example, an incident of choking occurred, and it was recorded the staff member continued to give the person the same food after the choking incident.
● Despite staff completing training in some areas such as safeguarding, the provider failed to assess staff competency in this area. We found staff were not always competent and did not fulfil their requirements in regard to safeguarding.
● The provider had not ensured staff had received practical training relevant to their role. For example, one staff member told us that practical training in de-escalation techniques were not available to staff and that some staff were not as confident as others when supporting people who were distressed.

The provider had failed to ensure there were enough skilled and competent staff in the service. This is a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff received support in the form of supervisions from senior management. Staff told us since the new management team have come into post, they felt more supported. One staff member told us, "We can always ask for extra supervisions if we feel we need to raise anything".

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

- It was unclear whether people were receiving a nutritious and balanced diet. The daily notes did not consistently detail what people had to eat throughout the day. The home manager was aware the daily record keeping needed to be improved.
- The service did not have menus displaying what was on offer for that day or for the week. The home manager told us they used to display pictorial menus, but this had not happened consistently and was aware this was an area for improvement.
- People were supported to be weighed if this was highlighted as a need in their care and support plan. Care plans detailed people were weighed regularly and any significant losses or gains in weight were acted upon.

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

- People were supported to access health care professionals however, the care that was delivered by staff was not always effective or followed health care professionals advice. For example, people were prescribed physiotherapy treatment by occupational therapists and staff were not consistently supporting the person to achieve this.
- People had health passports which were used by health professionals to support them in a way they needed. For example, health passports detailed any allergies the person had.
- People were referred to healthcare professionals to support their wellbeing. For example, people were supported to see or speak to a GP if they were unwell. People were also supported to see chiropodists and physiotherapists where this need was identified

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

- The design, layout and furnishings in the service did not always support people's needs. Some people's rooms were bare and did not look or feel homely. Some rooms in the home looked tired and worn and were in need of repair.
- Most of the bedrooms in the service were personalised with peoples' belongings. However, we noted there were bedrooms which did not have any personal effects.
- The home manager identified there were rooms that needed updating and 2 bathrooms that needed renovating. They were in the process of implementing the work to be carried out.
- The service had cinema room which was in use at the time of the inspection. The service also had a sensory bath which staff told us was used by a number of people.

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.

● People with restrictions in place did not always have documented evidence that this was the least restrictive option. For example, some people had audio monitors so staff could check on their safety. However, there was no record there had been a best interest meeting to discuss this with people's family. Following inspection, the home manager spoke to families to discuss the use of audio monitors.
● One person had their toiletries locked away due to the health and safety risks. There had been no capacity assessment or best interest meetings to ensure this was the least restrictive option for that person.
● The provider had ensured people who needed a DoLS, had one in place and that it was up to date.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● People's privacy had not consistently been respected. Some people did not have any curtains or blinds up at their windows. Some people only had a privacy film over their windows. Not all people had been supported to be independent to ensure they could make their own decisions around how they lived, for example if they wanted curtains to block out light or to use curtains or blinds for their privacy.
● Some people's possessions were not always respected by staff. For example, some people's clean clothes were crumpled into draws, staff had not always taken the time to ensure they were put away. Some peoples' furniture was broken and in need of repair or replacement.

The provider had failed to ensure people were always treated with dignity and respect. This is a breach of Regulation 10 (dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The home manager and staff had supported a person to become more independent. They identified the needs of a person had changed and they were supported to move into their own self-contained flat next door. Staff told us this had a positive impact on the person and there were visible differences.

Ensuring people are well treated and supported; respecting equality and diversity
● People were treated and supported well. We observed kind and caring interactions between staff and people in the service. For example, we observed a staff member being engaged in a conversation with a person and being reassuring.
● People's care and support plans contained details around culture and religion where relevant. For example, a person care plan highlighted they were of Christian faith but were not currently practising.
● People's care and support plans detailed their likes and dislikes. For example, a person's care plan described they liked dogs. There were pictures of this person when dogs had come into visit the people in the service.
● One relative gave positive feedback, they said, "[person] is looked well, we would know the signs if [person] was unhappy."

Supporting people to express their views and be involved in making decisions about their care
● People were supported to express their views. We observed staff members offering people a choice of lunch.
● One staff member told us, "I treat them all with respect. I always offer them choices, I always ask. Its respectful to do that. It's their dignity. If we didn't give them a choice, what to have for lunch or if to go out

then we wouldn't be respecting them."
● Another staff member told us how 1 person expressed their views, they told us, "[person] will tell us what they don't want, they will push away any item that they don't want."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Care plans were not always consistent to ensure people received personalised care to meet their needs. Care plans did not consistently contain information around people's aspirations or goals and how they would be supported to achieve them. The home manager was aware of this and was in the process of implementing a way to document the support people required.
● Care plans were not consistently person centred or reflected the person current needs. For example, one person's care plan detailed they needed half hourly checks overnight but when we spoke to staff, they us told us they did not do this as the person was a light sleeper and opening their door would wake them. Staff told us they used an audio monitor instead.

The provider had failed to ensure people's care was person centred. This is a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff that knew people well, knew their likes and dislikes. This included what activities people liked to do and what they liked to eat and drink. For example, staff told us 1 person likes to go to the local shop to pick up their favourite items.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were not consistently supported to take part in activities as and when they wanted. Staff told us they do not have many staff that drive which made supporting people to go out when they wanted difficult. One staff member told us, "I think more day trips. More trips to the zoo. They have their own weekly allowance. At the minute it's that we don't have the drivers on."
● People did not have activity planners in place. It was difficult to understand how people spent their time as it was not always clear in their daily notes what they had done that day, week or month. The home manager was aware this was an area for improvement.
● One person was supported to regularly visit their family members. They had an effective support plan in place which included them using their own car.
● People that were able to, could leave the service independently. We observed people were going to local the shop to get snacks and drinks.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have

to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People had individual communication passports that detailed effective and preferred methods of communication. One person's support plan detailed they were not able to communicate verbally with words but could understand what people were asking or talking about.
● We observed a staff member was using body language and signing with a person. The person appeared to understand this form of communication and was receptive.

Improving care quality in response to complaints or concerns
● The service had a system in place to deal with complaints. The home manager told us they had not had any complaints.
● The home manager told us they received compliments but did not always log these so they could be shared with staff.

End of life care and support
● People and their relatives were involved in the discussions surrounding their end of life care. The information was available in people's care plans.
● Staff told us this was not always an easy topic to discuss with families and if they did not want to discuss this, it was recorded in the person's care and support plan to be followed up at a later date.

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

● Governance processes were not effective and did not help to hold staff to account, keep people safe or provide good quality care. The provider failed to ensure that the management team at White Cliffs Lodge had sufficient oversight of the service to address any shortfalls.
● The provider failed to ensure systems were in place to keep people from harm. The provider did not have an effective and robust system in place to ensure there was oversight and analysis of incidents, accidents, and people's behaviours. We identified incidents where people suffered harm or distress, some which were avoidable. For example, avoidable incidents where a person had choked and incidents where a person felt unsafe in their own environment.
● There was not a system in place to have oversight of people's epileptic seizures. Seizures were recorded by staff however there was no analysis in place to identify if there were any trends or patterns to people's seizures.
● People's support plans did not consistently contain up to date and relevant information. Daily notes were in a format that did not allow the home manager to analyse and pick out and trends or patterns. There was little detail written for night staff to ensure people were getting the care and support they needed. For example, on a number of days, 'no concerns' was the only written entry for the night shift.
● The provider had not ensured that all legal requirements were met. We identified notifiable incidents that had not been reported to CQC or the local authority.
● Service audits were in place but were not robust enough to identify and act on issues we found during inspection. For example, window restrictors were part of the auditing process, however, we found window restrictors unlocked during our inspection.
● The provider had failed to ensure staff had the skills and knowledge to support people safely in line with best practice. Staff told us they had requested training for extra support but this was not facilitated by the provider.

The provider failed to monitor and mitigate the quality of the service and to individual people using the service. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● The new home manager and deputy manager were in a transitional period and were clear about the issues identified and they had a service development plan in place to implement the necessary improvements.

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

● There had not been a culture of care instilled into the service. The home manager and senior leaders had identified issues with the culture of the service and how staff were supporting people. For example, staff had not always followed people's care and support guidance, there was a lack of respect for people's personal belongings and incidents of poor care were not consistently reported.
● The provider could not assure us they were consistently meeting CQC's Right Support, right care, right culture (RSRCRC) guidance. For example, care plans were not always person centred and did not detail peoples' goals and aspirations.

The provider had failed to ensure people's care was person centred. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us since the home manager was in position, there had been improvements in how valued and respected, they felt. One staff member said, "I think they [management] have handled the change really well, the support they give is brilliant."
● Management were visible in the service, approachable and took a genuine interest in what staff, people, families and other professionals had to say.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had only recently sought feedback from relatives in the form of questionnaires. The home manager was in the process of gathering feedback and waiting for further replies for them to analyse the results for any trends to be identified and potential action to be taken.
● The home manager had carried out a staff meeting in the short time of them being in post. The home manager was committed to keeping staff up to date with the changes and their future plans for the service. This included discussing areas they felt needed improvements. The home manager told us they gave staff the opportunity to feedback what they felt the senior management team could improve on.
● Staff gave positive feedback about the new management team. One staff member told us, "The other day I told them the broom was de-threaded and within 2 hours I had a new broom. It's the same really for everything. If the blender broke within an hour we would have another one."
● The home manager had identified a need for 1 person to be supported by an advocate and had recently implemented this. An advocate is someone who supports another person to express their view and wishes, and helps people stand up for their rights.
● The home manager worked in partnership with other professionals such as the mental health crisis team, police and ambulance service. When concerns were identified regarding safeguarding issues the home manager work with the local safeguarding team.

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 could not always be assured they had been open and honest with people because staff had not consistently recorded or reported incidents to senior management. Where incidents were reported, families were informed.
● Relatives told us they were informed of incidents or accidents. One relative told us, "They [service] do give me a call if [person] has had a fall or anything."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people consistently received person centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were consistently treated with dignity and respect

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people or do all that is reasonably practicable to mitigate risks.

The enforcement action we took:

impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were established and operating effectively to prevent the abuse of service users.

The enforcement action we took:

impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to monitor and mitigate the quality of the service and to individual people using the service.

The enforcement action we took:

impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy enough suitably qualified staff

The enforcement action we took:

impose condition