Flarepath Limited

Stepping Stones

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Stepping Stones is a residential care home providing personal care to four younger adults with a learning disability and/or autism at the time of the inspection. The service can support up to four people and was provided in a newly built house. The service was established for short- or medium-term accommodation to assess and provide specialist support for people living with a learning disability or autism. The aim is for people to develop their skills and independence to move onto other appropriate long-term accommodation.

People's experience of using this service and what we found
People we spoke with did not describe being happy living in the service or living meaningful and fulfilling lives. One person told us, "I put up with a lot of rubbish here. I don't do anything. I just come down and make a coffee and go back to my room. I don't talk to anyone here…I want to be in hospital as they look after you there." Another person told us, "I want to go out, but they won't take me out, so I go to bed all day and just get up to smoke and eat and drink."

Incidents of potential abuse were not always reported to the local safeguarding authority and CQC. Incidents were not consistently recorded and there was no management and oversight of incidents by the provider. Care plans and risk assessments were not updated following incidents and there was no action taken to avoid reoccurrence. This put people at risk of harm.

Staff were not always recruited safely as employment gaps were not explored on interview. Staff with offences on their Disclosure and Barring Service check (DBS) did not have adequate risk assessments in place to manage this risk.

People were unlawfully physically restrained by staff who had not received up to date training in restrictive physical interventions and positive behaviour support. Staff lacked the skills, knowledge and guidance to support people safely and to meet their needs. Inappropriate punitive practices were used to manage people's behaviour such as sending people to their bedrooms and not letting people do the things they wanted to do. This often resulted in people's behaviour escalating and staff lacked the knowledge to identify this. The provider had failed to recognise this was a form of secluding people.

There was a complete lack of infection prevention and control management which put people at significant risk of harm from Covid-19. Staff were not wearing face masks; people had not been tested regularly and had not been encouraged to social distance in their home. The service had a Covid-19 outbreak in December 2020 and every person had tested positive for Covid-19. Despite this the provider had continued to not follow government guidelines for Covid-19.

There was no governance in place by the provider to ensure people received safe, quality care. The registered manager and provider failed to complete any quality assurance of the service and failed to

identify the concerns we found during our inspection. The registered manager and provider had failed to meet all their regulatory requirements. For example, the failure to notify CQC of safeguarding incidents.

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

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

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The model of care and setting did not maximise people's choice, control and independence. People were not empowered to make day to day choices, enabled to take control of their care and enabled to be as independent as possible. This meant people were disempowered in all areas of their lives and not enabled to live their life to the full.
Right care:
• Care was not person-centred and did not promote people's dignity, privacy and human rights. Staff lacked the knowledge and skills to support people in a person-centred way. Staff lacked understanding of learning disabilities and autism and how to support behaviour that challenged in a positive way. People were not supported in a person-centred way and interactions lacked respect. For example, when one person became distressed due to waiting to go out, they were told to, "Leave staff alone and they will be ready when they are ready."
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives. The lack of understanding by the registered manager and the resulting attitude and values displayed by staff had led to a negative culture in the service. The registered manager and staff spoke about and to people in a derogatory way. For example, staff said "If you read about (person) on paper, you wouldn't touch them with a barge pole" and, "(Name) was trying to get out of the door and have a go so we did them in a seated restraint until they calmed." This had a negative impact on people's self-esteem, confidence, human rights and quality of life.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 4 March 2020) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the safeguarding management of an incident. As a result, we undertook

a focused inspection to review the key questions of Safe and Well-led only. We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, fit and proper persons employed and notification of other events.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Stepping Stones

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by one inspector.

Service and service type
Stepping Stones is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
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 safeguarding authority and a commissioner who works with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the

judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with 5 members of staff including the nominated individual who is also the registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the deputy managers, a team leader and support worker.

We reviewed a range of records. This included four people's care records and 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 incident records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures. We spoke with other commissioners who work with the service.

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 Requires improvement. At this inspection this key question has now deteriorated to Inadequate: This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to complete checks on staffs conduct in previous roles and their good character. This placed people at risk. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 19.

● People remained at risk of being supported by unsuitable staff. Staff were still not always recruited safely. There were gaps in the employment history for one staff member from 2005-2009 which had not been explored on their application. This was for a staff member with criminal offences of physical assault on their Disclosure and Barring Service record which is a criminal record check. The risk assessment for their offences was not adequate to mitigate the risk to people of this person working with them. There had been an incident involving this staff member of unlawful physical restraint against a person living at the service.

The provider failed to ensure persons employed were of good character and failed to ensure appropriate and timely action was taken in response to this. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service was short staffed with two vacancies they were trying to recruit to. This meant the registered manager and one deputy was working shifts. This had an impact on their ability to fulfil their duties to manage the quality and safety of the service. The registered manager informed us there were three staff on duty at night who supported people at this service, and the providers other service next door. However, rotas showed that there were not always three staff working at night. One person told us they were not allowed to come downstairs at night as staff were sleeping on the sofa. We asked the registered manager to investigate this.
● Staff did not have the skills and qualification to fulfil their role and meet peoples' needs. People were at risk of being supported by staff who were not qualified or competent. There was a lack of staff training to ensure staff could support people safely. The registered manager and staff had not received up to date training in current practices in Positive Behaviour Support (PBS) and the use of restrictive physical intervention.

The provider failed to ensure that persons providing care to people have the qualifications, competence and

skills to do so safely. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff had received an induction to the home and were given the opportunity to shadow more experienced staff.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse. There was a lack of understanding of safeguarding procedures by the registered manager who had failed to recognise an incident of unlawful restraint and verbal abuse on a person as a safeguarding concern. The provider had not followed their own policies on safeguarding at every stage. The provider had failed to adequately investigate the incident, for example they had not explored discrepancies in staff's statements of events. The provider also failed to review the incident and identify actions needed in response to protect people from the risk of further harm.

● The provider had failed to protect people from abuse occurring by the employment of a potentially unsuitable staff member without adequate risk assessment. The provider failed to report the incident to the Disclosure and Barring Service (DBS) following their investigation and only did so on the insistence of the local safeguarding authority over two months after the incident. Providers are required to inform DBS for possible inclusion of the staff member on its barring list as someone who is unsuitable to work with people in a vulnerable setting.

● The provider had not notified the local safeguarding authority and CQC of all safeguarding concerns. For example, one person had been injured during an incident which included the use of restrictive physical interventions. The person had broken a finger and whilst it was not known if the injury was a result of the physical intervention or the person's own movements, this had not been investigated or reported externally.

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

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

● The provider failed to mitigate risks to people. Risks around people with behaviour that challenged were not effectively managed. Incidents were not always recorded. For example, incidents of behaviour that challenged were described to us by the registered manager or staff but there were no records for these. This included incidents when restrictive physical interventions had been used.

● One person told us, "I have been restrained a few times but not this year so far. I don't like it, it's their job, that's what they have to do. Sometimes I hit out at staff, I go to hit them, they will restrain me, either floor me gently or escort me to my room. I have been restrained a lot since I have been here." We reviewed the incident records for this person and there was only one reference to the use of physical intervention in July 2019. The only details recorded were that the person hit a staff member which caused the staff member to restrain with another two members of staff.

● There was a lack of review following incidents and lack of appropriate action taken to ensure people's safety and prevent reoccurrence. For example, one person had thrown a heavy object at staff in the garden, their risk assessment stated to, 'remove all potential missiles', yet the garden was littered with objects which could be thrown, such as discarded televisions, broken garden furniture and garden tools and equipment. The provider had failed to identify the failure to follow the control measures in the person's risk assessment to reduce the risk to people and staff.

● People and staff were at risk of harm from inappropriate use of restrictive physical intervention. People with behaviour that challenged were not supported in line with current best practice in the use of restrictive physical intervention. The use of any restrictive physical intervention should be a last resort and requires an

assessment and agreement and must be reviewed after every use. This should include the specific interventions appropriate to be used with people and in what situations. There had been no risk assessments completed for people on restrictive physical interventions and therefore no review or analysis following the use of restrictive physical interventions in the service.

● People with behaviour that challenged were not supported in line with current best practice in Positive Behaviour Support (PBS). The provider had failed to recognise the use of seclusion when people were 'sent to their bedrooms'. The provider had not analysed or recognised how staff members response to people may have caused or escalated an incident; and how if people's needs had been met, the incident could have been avoided. There had been no use of functional behavioural assessment or analysis in the service. Functional behavioural analysis is about identifying the reasons for the person's behaviour, what they are trying to avoid or what they are trying to achieve. This enables a better understanding of what the person is communicating and enables consideration of how a person's needs can be met to avoid them any further emotional distress.

● Risk assessments were not always completed or had enough information to provide guidance to staff how to manage risks. For example, one person had a catheter in place but there was no risk assessment for this. This meant there was no guidance for staff how to support the person to manage the associated risks such as the increased risk of infection and how to identify and monitor for this.

● The fire risk assessment was overdue for review since Jan 2021. The provider could not be assured that all action had been taken to keep people safe in the event of a fire. The fire risk assessment identified shortfalls and set out actions needed, not all actions had been completed. Two people did not have Personal Emergency Evacuation Plans (PEEPs) in place. This meant staff did not have the guidance they needed about how to support the person safely in the event of an evacuation. We spoke to the registered manager about this and they said these are now in place.

● Bedroom checks were completed monthly. One person's check had all been ticked as satisfactory in January and February 2021 and had not been completed since. The person's room was unclean, the sink was very dirty and there was an overpowering smell of urine. Premises, garden and grounds checks had identified the need to repaint, the need to tidy up the garden and repair the shed but no action had been taken in response to this.

● The provider had not completed any review or analysis of incidents and had not therefore identified any learning from incidents. There was no log of incidents to provide an overview of incidents in the service to help identify any trends. Incident reports should be reviewed to prevent reoccurrence and for learning opportunities. People and staff were at increased risk of avoidable harm because the provider was not always recording, reviewing or learning from incidents.

The provider had failed to assess and mitigate 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.

● Other environmental risks were managed and there were regular checks and audits in place to ensure management oversight of these. This included testing for legionella, fire alarm, emergency lighting and firefighting equipment servicing, water temperatures and fridge and freezer temperatures. Gas and electrical safety had been checked and certificates were in place to evidence this.

Preventing and controlling infection

● The prevention of infections and the Covid-19 pandemic was not managed. People and staff were at risk of and had contracted Covid-19 which put them at risk of serious harm. An outbreak in December 2020 led to all four people and 17 staff contracting the virus. We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There were no Covid-19 policies, contingency plan, risk assessment and infection prevention and control (IPC) audits for provider oversight in the service.

● We were not assured the provider was using Personal Protective Equipment (PPE) effectively and safely. The provider had failed to follow current guidelines around Covid-19 with regards to staff wearing PPE. Staff were not wearing any PPE when they should be wearing masks as a minimum. The registered manager informed us the decision had been made not to wear masks due to people being 'freaked out' by the masks and the impact this had on communicating with people. We did not observe any reaction from people from our use of masks. Alternative solutions had not been sought and the registered manager had not kept up to date with changing guidance. There was no identified PPE station in the home for staff to put on and remove their PPE safely.
● We were not assured that the provider was accessing testing for people and admitting people safely to the service. There was no risk management when a person refused to self-isolate on admission or when people refused to have a Covid-19 test. There was no advice sought about how to manage this and people had not been supported to make an informed choice. There had been no mental capacity assessments to determine if people had the capacity to make these decisions and no best interest process completed for people where they did not have the capacity.
● We were not assured that the provider was meeting social distancing rules and promoting safety through the layout of the home. The home did not look clean, floors and surfaces were dirty. There was a lack of any social distancing in the home, especially at some mealtimes, when there was a small table of people and staff seated closely in the kitchen. Whilst this was a small house which makes it difficult, there had been no attempt to manage this. For example, by the layout of the furniture. The provider had failed to follow the government guidelines to ensure they worked separately to their other location next door. Staff are required not to work across care home locations to minimise the potential spread of Covid-19, but staff were working across the providers two care homes.
● We were not assured the provider was preventing visitors from catching and spreading infections. There were no checks completed with us on entering the home.

We have signposted the provider to resources to develop their approach. The provider has responded following the inspection with Covid-19 policies and a risk assessment. This addresses our concerns around the effective use of PPE, testing and visitors catching and spreading infections.

The provider failed to assess the risk of, prevent, detect and control infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The registered manager confirmed that visitors had not been unnecessarily restricted.
● We were assured staff were accessing testing in line with guidance.

Using medicines safely
● People had received their medicines as prescribed. However, medicines were not always managed safely as medicines administration errors were not identified. For example, there were gaps on people's Medicine Administration Records (MARs) that had not been checked. Medicines were counted daily and stocks accounted for. These showed that gaps in people's administration records were not signed for rather than not given. In another instance there were gaps as the person had been away visiting family and this had not been recorded on the person's MARs. No action had been taken in response to these administration errors.
● People's medicines were not administered in line with best practice guidelines. There were no protocols in place for 'As required' medicines to guide staff when these should be used and to monitor effectiveness. Lack of guidelines around administration increases the risk of medicine errors.
● There was no management oversight to ensure people had their medicines as prescribed. For example,

medicines audits had not been completed. Staff competency checks with medicines were not completed. The provider could not be assured medicines were always managed safely.

The provider failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Controlled drugs were administered safely. These were securely stored, signed by two staff when administered and counted daily.
- Medicines were monitored to ensure they were stored at safe temperatures to maintain their effectiveness.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a negative 'us and them' closed culture in the home. The registered manager and staff used disrespectful and outdated language when talking about and with people. People were disempowered as staff treated them like children and failed to give them the choice and control over their own lives. People did not receive person-centred care and were at risk of psychological abuse
- The approach to the management of behaviour that challenged in the home was punitive and lacked understanding of people's needs and human rights. Records described how people were 'made to wait until staff were ready', people were 'sent to their rooms to calm down', people were told that staff 'refused to discuss things as they didn't like them at the moment as their comments were out of order'. People were not always effectively supported when they were upset and angry and were at risk of psychological harm and physical harm from unlawful physical restraint.
- People were not supported in line with the principles of Right support, right care, right culture. People were not always given choice and control and their quality of life was not maintained. One person told us they could not go out when they wanted to although they had one to one staff all day. Two people told us they could not choose what they had to eat. People did not choose who they lived with. There was no learning from a previous failed placement, the provider had accepted the admission of another person with no transition and minimal assessments. The person had not met the people they would live with. This had also impacted on other people living at the home.
- People had not been given an informed choice about whether they wanted to be tested for Covid-19, how they felt about staff not wearing PPE and if they wanted to be vaccinated.
- The service was not in line with the provider's Statement of Purpose (SoP) and did not always achieve good outcomes for people. There had not been regular reviews of people's support, specialist support and plans to enable people to move on as detailed in the aims of the service. Goal planning records were either not completed or held very little information. Activity records showed one person had been out into their local community only three times since 16 December 2020.

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

- There had been no oversight and governance from the registered manager and provider. The registered manager had not ensured the delivery of high quality and safe care. The provider had not ensured they had good oversight of the safety and quality of the service. Quality assurance systems such as audits, checks and observations were not established to monitor and improve all aspects of the service. No audits had been

completed for medicines, IPC and care files. This is important to ensure staff are competent and have the guidance they need to provide and monitor safe, consistent support which meets people's needs.

● Appropriate action had not been taken to meet the breach of regulation 19 from the last inspection. The provider had not identified the concerns we found at this inspection and had not supported the registered manager effectively to manage the service. The registered manager confirmed there was no improvement plan in place for the service so poor practices had been enabled to continue.

● There was no drive on improvement by the provider based on continuous learning. There was a lack of feedback sought to learn from. The provider did not actively seek feedback about the quality of the service. There was a lack of review and analysis of incidents and other activities or outcomes to identify areas for improvement from lessons learnt. There were no formal plans to drive improvements to people's individual care and the service. This meant people were at significant risk of incidents re-occurring

● People's care plans and risk assessments were not reviewed and updated following incidents. People's care plans did not have all the guidance needed to inform staff how to meet their needs.

● Regulatory requirements had not been understood around the Mental Capacity Act 2005 (MCA). There was a lack of any Mental Capacity Assessments and when required related Best Interest Decision processes for people, for example around Covid-19 testing and vaccination. The registered manager did not work in line with the MCA as relatives had given consent to some decisions but relatives cannot consent for others unless they have the Legal Power of Attorney to do so. People had not consented to their care and the use of restrictive physical intervention, and decisions had not been taken in their best interests.

● The registered manager and staff demonstrated a lack of knowledge of current legislation, guidance and risk management. This included the lack of risk management of Covid-19 and the lack of risk management with Positive Behaviour Support and the use of restrictive physical interventions.

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

● There was a lack of feedback sought to learn from people, relatives and staff. People were not fully engaged with the service. People told us there had not been any meetings or surveys or other means to involve them in the service. People told us they were not always involved in their day to day care. For example, being informed what medicines they were taking and what these are for.

● Staff were not fully engaged with the service; team meetings were held but these did not evidence effective involvement. For example, they did not include discussion on recent incidents, lessons learnt, and improvements needed. No surveys had been completed with staff to gain their views on the service.

● There was a lack of partnership working with other stakeholders. Local authorities commissioning the care were not aware of incidents which had occurred with people.

● There was a lack of transparency with commissioners around how the provider managed their two locations as one, despite having separate registrations. The two locations were acting as one larger campus setting and this does not fit with the providers service model in their Statement of Purpose.

The provider failed to assess, monitor and improve the quality of the service. The provider had failed to assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate, up to date and complete records for each person. The provider had failed to seek and act on people' s views. This is a breach of regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt supported by the registered manager and could approach them with any concerns. The registered manger had started to catch up with supervisions with staff.

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 law requires providers to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The provider did not act on the duty of candour. Incidents had not always been reported to the local safeguarding authority or to the CQC as required by law.

The provider failed to notify the CQC of safeguarding incidents and/or serious injury incidents which is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● It is a legal requirement that a provider's latest CQC inspection rating is clearly displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgment. A copy of the inspection report was pinned behind other documents on a notice board in the kitchen. The provider had not ensured the ratings from their previous inspection were on clear display in the service.

The provider had failed to conspicuously display the most recent rating at the premises. This is a breach of Regulation 20A (Requirement as to display of performance assessments) of Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the CQC of safeguarding incidents and/or serious injury incidents.

The enforcement action we took:

Urgent conditions imposed on location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that persons providing care to people have the qualifications, competence and skills to do so safely. The provider had failed to assess and mitigate risks to people. The provider failed to assess the risk of, prevent, detect and control infection. The provider failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Urgent conditions imposed on location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from abuse and improper treatment

The enforcement action we took:

Urgent conditions imposed on location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The provider failed to assess, monitor and improve the quality of the service. The provider had failed to assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate, up to date and complete records for each person. The provider had failed to seek and act on people's views.

The enforcement action we took:

Urgent conditions imposed on location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure persons employed were of good character and failed to ensure appropriate and timely action was taken in response to this.

The enforcement action we took:

Urgent conditions imposed on location