Abbey Care Saxon Limited

Saxon Court

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
Saxon Court is a residential care home providing personal care to 18 people with learning disabilities or autistic spectrum disorder. The service can support up to 49 people.

People's experience of using this service and what we found
The systems and processes followed by the provider failed to identify that safe care and treatment was not provided. We identified eight incidents that had not been reported to the local authority under their safeguarding guidance nor had CQC been notified. There was no oversight of safeguarding incidents by the provider.

We observed long periods of time where no staff were available to help support people, some of whom required one to one support to ensure that people mobilised safely and prevent falls. Staff had multiple tasks to complete including covering for the cook who did not work at weekends and who was on leave at the time of the inspection and cleaning, to support a part time agency cleaner. Several people at the service needed the support of more than one staff member for personal care, transfers and safely moving around the service. Meeting these needs resulted in no staff being available to provide meaningful interactions for people.

Risks to people were not safely managed. Some people were at risk of choking but not all safety guidelines had been followed. Care plans were not always clear in reflecting people's needs and were not easily accessible to staff, this had resulted in a choking incident. Several people were at risk of falls and we saw that many falls had been recorded in daily notes but no effective audit had taken place to examine causes and to minimise recurrence. There were not enough staff to meet people's needs. Medicines were not stored or consistently administered safely. There was no oversight on medicine numbers.

The environment where people lived contained hazards and safe moving and handling practices were not consistently followed. The provider was not meeting government guidelines regarding Covid-19 in relation to the heightened cleaning regime care homes needed to follow during the pandemic. There were not enough staff to ensure the service was clean and hygienic and cleaning records were inconsistent. Parts of the service including the kitchen, had not been cleaned for several days. Individual Covid-19 risk assessments had not been completed for people or staff.

Staff were hard working but were not supported by the provider who was also the registered manager. Staff told us they rarely saw the provider at the service and did not have daily access to support and guidance from them. There was no oversight of auditing processes by the provider and care plans did not reflect the actual levels of care and support provided to people. Staff supervision meetings were inconsistent.
We requested several documents and updates from the provider during and immediately after our inspection relating to staffing, oversight of the service and people's safety. Not all of these documents were received, and many were sent after deadlines.

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.

Based on our review of safe and well-led the provider 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. There were locked doors throughout the service separating parts of the service. We discussed this with staff, some locked doors were in place to protect people's safety to prevent people from accessing the stairs without staff support where there was a risk to the person. For locked doors on the ground floor, staff told us if there were enough staff to support people safely, the locked doors would not be required. One person did not have a mental capacity assessments or best interest decisions around being behind a locked door. We saw that one person who was at risk of falls who wanted to walk around the service was frequently brought back to an armchair to sit down. Staff told us and we observed that staff did not have enough time to walk with the person. Guidance states that services should be designed so that the environment does not feel institutional, we saw many signs around the home identifying the service as a care home. This included people's personal information such as a poster on the wall which indicated what people's fluid requirements were and which care forms needed to be completed for each person.

Right care:
• Care was not person-centred and promotes people's dignity, privacy and human
Rights. People were not engaged in meaningful occupation and told us there was nothing to do. One person said, "I'm bored. Are you bored? Isn't it boring here, there's nothing to do." People's care plans clearly detailed people's hobbies and interests. During our inspection, we did not see any of these interests or hobbies being supported. We observed staff did not have time to spend with people to sit and talk to them. People were left on their own for long periods of the day. People's daily notes did not show any activities taking place. Staff told us that due to the lack of staff, people were not able to choose how they spent their day or to go out if they wanted to. One staff member told us how two people would love to go out to lunch today but couldn't because there was no one to take them, the staff member commented, "People in prison get more opportunities than the people here."

Right culture:
• The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives. Staff told us that they had raised multiple concerns around staffing levels with the provider and felt their concerns were ignored. Care staff were kind and caring but felt that they were failing people by not being able to provide safe care or opportunities for people. Staff told us the immense pressure that they felt under in trying to provide support for people at the service. Staff told us that the lack of activity and engagement impacted on people's moods. We saw that people spent long periods of the day without meaningful interactions, staff said hello as they walked past but were not able to spend any time with people.

Rating at last inspection (and update)
The last rating for this service, following a comprehensive inspection was good (published 7 June 2019). A focussed inspection to look at safe and well-led (published 7 March 2020) identified improvements were needed in well-led because auditing systems, policies and procedures were not always robust enough to

ensure that there was sufficient oversight of the management of people's finances. However, the overall rating for the service remained good.

At this inspection we found breaches of regulation and the service has been rated inadequate.
Due to the level of concerns identified at the inspection, we notified the Local Authority who took action to provide support for staffing and review people's needs.

Why we inspected
We received concerns in relation to the lack of staffing at Saxon Court. 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. 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.

The overall rating for the service has changed from good to inadequate. This is based on the findings 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 Covid-19 and other infection outbreaks effectively.

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

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 Saxon Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the Covid19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to people's safety staffing, medicines, quality assurance and notification of other incidents at this inspection.

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

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

Follow up
We will 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.

Special Measures
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?

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.

Saxon Court

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. They were also the provider for the service and are legally responsible for how the service is run and for the quality and safety of the care provided.

The provider had delegated the day to day running of the service to a deputy manager and a compliance manager.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spent time talking with and observing people's interactions with staff. We spoke with seven members of staff including the provider. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and induction. A variety of records relating to the management of the service, including audits, policies and procedures were reviewed.

After the inspection
We sought immediate reassurances from the provider about people's safety and staffing levels. We received feedback the relatives of five people who lived at Saxon Court. We looked at staffing rotas, training data and quality assurance records. We spoke with two professionals who regularly visit 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 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

- There were no systems or processes to ensure people were protected from harm or abuse.
- The provider did not have oversight of safeguarding incidents and had not reported safeguarding concerns to the Local Authority Safeguarding team or to CQC. Eight separate incidents were identified which should have been reported to the local authority safeguarding team and to the CQC. These included where a person had been involved in a choking incident and a physical altercation between two people. We discussed this with the provider who told us they did not know that these incidents had not been reported or why these incidents had not been reported.
- We discussed safeguarding incidents with staff who completed incident forms for safeguarding concerns. Staff told us that they were prevented from reporting these concerns to the safeguarding team by the provider as he wanted to do this himself.

People were at risk of harm and abuse because the provider had not implemented systems to protect them. This is 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

- Aspects of the environment were not safe. In one area of the service, the door thresholds were not flush to the floor. This meant that people in wheelchairs had to be lifted, by staff, over these thresholds to move between rooms. For people that walked independently and were at risk of falls, these were trip hazards.
- Some people required modified food consistency due to being at high risk of choking. Care and agency staff were responsible for changing the consistency of food when the cook was not present. For one person, their SALT (speech and language therapist) guidance had not been followed, resulting in the person being provided with food of an inappropriate consistency, leading to them choking. Their care plan following this incident still did not provide clear guidance for staff on how to support this person. This therefore exposed them to increased risk of further choking incidents.
- People who were at risk of falls were not always supported safely. One person who required support to walk around was frequently seen walking around without support. This person was sat on a chair sensor which should alert staff if the person tried to stand without support. The chair sensor did not have a plug and did not work. This meant staff were not aware when this person was walking without support and was at risk of further falls which could result in injury or harm.
- People were not supported safely with their mobility needs or in accordance with their care plan. One person had fallen from their bed and staff had raised the person from the fall using unsafe moving and

handling practices. This had caused injury to the person requiring medical attention. When this was raised with staff it was not clear what action had been taken in response to this incident. Staff told us they had reported this to the provider but had not been informed of any actions taken to prevent reoccurrence.

● Other environmental risks had not been addressed. For example, a thorough examination of lifting equipment must be carried out every 12 months; or every 6 months when used to lift people, or for any lifting accessory. There must be a report which must include the date of the thorough examination and the date the next one is due. The report that the provider supplied to CQC was dated 30 January 2019. This meant the provider could not be assured that equipment used to support people with their mobility was safe.
● A member of staff told us they had reported an en suite shower in an occupied bedroom that was not working, in February. At the time of the inspection the shower had not been repaired.
● Although accidents, incidents and safeguarding's had been recorded by staff, they had not been reported appropriately or investigated to determine causes. Therefore, there was no evidence of any analysis to identify themes or trends or any evidence of actions taken to prevent a recurrence.

Risks to people were not always identified and addressed. When they were identified appropriate action was not taken to mitigate risks and protect people from harm. This is a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were shown in date documents relating to legionella checks and electrical safety.

Staffing and recruitment
● Staff told us that there were not enough staff to support people safely. One staff member told us, "The service should be shut down because it just isn't safe". A whisteleblower contacted us and told us that staffing was insufficient. The local authority contacted us with concerns about staffing numbers.
● We observed long periods of time where people were left on their own in communal areas without the support of staff. During our observations we saw that one person who was at high risk of falls had been assessed as requiring staff support to mobilise safely. We saw this person stood up, left the area and returned on four occasions without staff support, inspectors had to intervene and inform staff to ensure the person's safety.
● All aspects of the service were affected by the lack of staff. Care staff were responsible for multiple roles including providing meals and cleaning the service. There was no cook at weekends and the member of cleaning staff worked only four days a week. These additional roles took staff away from supporting people safely. People were left on their own for long periods of time and did not receive appropriate support from staff. A member of staff told us, "There is no weekend cook so we have to do it. Often there is no one on the floor."
● Staffing levels were determined by a dependency tool which calculated the hours of support a person needed with different tasks. Staff told us that they had been told to change the amount of hours people needed for activities and social interaction to lessen the amount of staff indicated by the tool. A staff member said, "Personal care often runs into late morning." We saw staff providing personal care to people in order to support them out of bed up until lunchtime. Due to staffing levels, people were not able to get up at their preferred time.
● Where there were staff absences, these were covered by agency staff. Two agency staff were present at the time of our inspection. One of the agency staff had not been to the service before and did not know people or their support needs. One person became frustrated with this staff member because they would not give them a drink before checking with the permanent staff. This meant the person had to wait 10 minutes for a drink until the permanent staff had finished supporting another person.

● There were no meaningful occupations for people and people were rarely engaged. One person told us, "I just sit here and fall asleep. Not much to do because I can't see well. I sometimes look out the window, but I don't go out. The people here are nice, but there's not much to do." Staff told us that not being able to provide people with activities and engagement due to low staffing levels had caused people to be low in mood and at times become withdrawn. We observed one person who wanted to walk around the lounge but required staff support which was not available. Staff repeatedly brought the person back to a chair and asked them to sit down. This person then sat with their head in their hands, moved backwards and forwards in the chair, then laid down on the sofa and went to sleep.
● When agency staff worked at the service for the first time they were provided with basic information about people and general house rules. However, there was no evidence of any induction to introduce them to the day to day running of the service, fire safety or to identify their knowledge about supporting people with a learning disability or dementia.
● Due to the level of concerns around staffing levels identified at the inspection, we notified the Local Authority who took action to provide support for staffing and review people's needs.

This meant the provider could not be assured that there were enough staff to ensure people were safe or received the care and support they required in a safe way. This is a breach of regulation 18 Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It was clear that staff wanted to provide a good service for people but due to staffing issues did not have the time to provide good care. One staff member told us; "It's heart-breaking. You want to spend time with people. For some people we are all they have, and we can't even sit for five minutes and hold their hand. We are failing them."
● Recruitment files demonstrating staff were safely recruited to the service and contained Disclosure and Baring Service (DBS) certificates. DBS checks are made to ensure prospective staff have no cautions, criminal convictions or other reasons that would prevent them working with vulnerable adults. The provider told us that recruitment had been impacted by political events and the Covid-19 pandemic.

Using medicines safely
● Medicines were not always managed safely. Medicines that required two staff to administer, according to the provider's policy, were only being administered by one member of staff. Staff told us this was not being done due to a lack of trained staff. Medication administration records (MAR), confirmed that the provider was not aware that only one staff member was administering these medicines. This meant there was an increased risk of a medication error.
● Systems were not in place to ensure there was oversight of medicine stock levels. Staff were not counting medications as they were being given, to ensure none were missing. Staff told us that this was something they used to do but due to staffing levels, did not have time to do anymore. Monitoring stock levels for individual boxed medicines is important to minimise the chance of error and ensure people received the prescribed amount of medication.
● People's medicines were stored in two different medicine trollies attached securely to the wall in communal areas. However, there was no recording of room temperatures for these rooms. Medicines can become less effective when subjected to high temperatures.

This meant the provider could not be assured that people received their medicines safely and is a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had medicines administered on an as needed basis 'PRN', for example pain killers. People

had protocols in place for these medicines that showed staff how to identify signs that someone may need their PRN medication. We saw staff offer people their PRN medicines at each medication round. For people who were not able to say if they required pain relief, an abbey pain chart was used to determine if the person's body language and facial expressions indicated they were in pain.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. There were not enough housekeeping staff to maintain cleanliness. At the time of the inspection the housekeeper and the cook were on leave. A part time cleaner had been employed to cover but only worked up to four hours, Monday to Friday and cleaning records were inconsistent. The kitchen had not been cleaned for five days. We found a rota of cleaning duties for night staff. This contained no detail of the areas cleaned and we found gaps where it appeared no cleaning had taken place. Cleaning schedules were difficult to follow and did not clearly record when people's rooms had been cleaned. The provider had not ensured that cleaning of the service had been completed.

● One person's room smelled very strongly of urine; this was addressed with staff, but no action was taken. We did not see any staff cleaning frequently touched surfaces. The provider was not following government guidelines regarding Covid-19, in relation to the heightened cleaning regime for care homes that was in place at the time of inspection. Night staff were responsible for a high proportion of the cleaning in addition to supporting people throughout the night.

● A relative told us that on occasions the service did not always look very clean. They gave the example of an overflowing ashtray in the garden. They told us, "You wouldn't leave it like that at home so it shouldn't be like it here."

● Although there was space at the service, in the event of an outbreak there was not enough staff to support people safely whilst maintaining social distancing and supporting people who remained in their rooms.

● Whilst we were assured that the provider's infection prevention and control and Covid-19 policy was up to date this had not been followed. The policy stated, 'Saxon Court Care Home needs to ensure that residents and staff who are considered particularly vulnerable to Covid-19 have a risk assessment in place.' However, risk assessments had not been completed for people or staff.

● We were somewhat assured that the provider was admitting people safely to the service. We were told there was an admission policy in place but it was not clear if this had been followed when people were admitted to the service.

This meant the provider could not be assured that people were protected from the risk of infection and is a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections. Visitors to the service entered through a separate entrance and had a lateral flow test before visiting their loved ones.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 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 requirement. Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Continuous learning and improving care, working in partnership with others

At our last inspection we asked the provider to make improvements to the auditing systems, policies and procedures to ensure robust oversight of the management of people's finances. At this inspection improvements had been made in relation to the management of people's finances. However, we identified serious concerns in relation to other aspects of the management of the service.

● The culture at the service was not always positive. Staff were committed and worked hard to provide a good standard of care and support. However, this was not always possible due to the lack of staff available to meet people's needs. A member of staff said, "We are task driven. There is no time to meet social needs. Another told us, "I can just provide what people need but never what they want."
● The provider told us staffing had been impacted by political changes and the pandemic. We identified that people's assessed staffing needs were not accurately assessed which underestimated the assessed care staffing levels needed. Staff told us that the provider had failed to respond to concerns raised about safe staffing levels.
● Care plans did not reflect the actual level of care provided in order to support consistency of care and support. Although care plans recorded people's interests, likes and dislikes as well as their health and social needs, staff did not have time to spend with people to fully support all of their needs.
● Some auditing had been carried out by staff for example medicines and kitchen audits. Some audits had not been reviewed for some time for example accidents and incidents. The most recent audit we were initially shown was dated 2019. More recent audits were found but they lacked detail, or any evidence of lessons learned or steps taken to minimise future incidents. There was no oversight of auditing by the provider. Medicine audits had shown that some medicines that were required to have additional recording measures in place were only being administered by one staff member and that medicine stocks were not being checked The provider was unaware of these issues due to the lack of effective quality monitoring.
● Staff did not receive consistent formal supervision meetings. One staff member told us they had never had a supervision meeting. Another staff member said they did have supervision but felt it was something that 'had to be done' rather than having any benefit. The provider did not have oversight of a formal supervision

process.
● There were no team meeting minutes available although we were told a meeting had taken place recently. We were also told the provider was absent from that meeting. We requested a copy of the minutes for this meeting but nothing were sent to us. The lack of minutes meant that staff absent from this meeting and agency staff may not have been kept up to date or aware of any changes in practices or guidance.
● The provider was also the registered manager. The provider did not support staff or provide visible leadership. Staff told us, "There is no leadership here. At the weekends there are no supervisors at all." Another said, "They (the provider) are indifferent. They are supposed to be here once a week but we rarely see them." Another told us that they had gone four weeks without seeing the provider at the service.
● We were shown a dependency tool, a document that assessed people's care and support needs and matched this to the number of staff on each shift. This document had not been recently updated to reflect the high level of support that several people required. Consequently, there were only minimal staffing numbers available for each shift. The provider had not ensured oversight of the service to identify and respond to staffing concerns.
● The service had previously employed an activities co-ordinator but had not recruited to this post once the person had left. This meant staff were responsible for providing meaningful engagement to people. People told us they had nothing to do and that their social needs were not being met.
● There were several internal doors that required keypad access codes and some people's movements were restricted. The provider told us that they were put in place to protect people as they had people that did not get along together. The provider told us that some of these people had now moved and agreed to an immediate review of these restrictions. We saw some people trying to open these doors.
● Although policies were in place these were not always followed. This included the medicine policy for some medicines and the Covid-19 and infection prevention and control policies where risk assessments and regular cleaning of high-touch points had not been completed.
● Throughout the inspection process the provider repeatedly failed to respond in a timely way to requests for further information from CQC and the Local Authority. The provider did not demonstrate that they operated in an open, transparent manner or encourage a positive culture.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were not effective systems for engaging and involving people. We were told the method for engaging with people was through resident meetings. The most recent residents meeting was held in May 2019, two years before the inspection. No other records of views being sought from people were found. No recent reviews were found on the service website or other websites associated with care home provision.
● There had been no recent engagement with relatives. The last request for relatives' feedback was dated 2018.

The provider had failed to establish and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not in place, accurate or complete. This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Relatives told us they were kept up to date with changes in their loved ones needs. One relative told us, "I did have to say something because I hadn't been told when [name] had a fall but now they do let me know." Another relative said, Staff were open to suggestions and they had a sound working relationship."
● One relative told us, "There are things I'm not always happy about and we do have to remind staff sometimes but [name] is safe, comfy, well-fed and happy."

● People's equality characteristics were considered and were referred to in care plans. These included for example any faith or cultural needs.

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

● Statutory notifications, which are required by law, had not always been submitted. We found nine incidents which should have been reported to CQC. Staff told us they reported incidents internally and there was some evidence of this from care plans. Staff told us the provider wished to report concerns to external organisations himself. However, this had not happened. Consequently, the provider had not sought advice or support from professionals for example, the local authority safeguarding team.

● Following the inspection, CQC received some of these notifications retrospectively.

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 Regulation 12(1) HSCA RA Regulations 2014. Safe care and treatment. Service users were not always protected from the risk of abuse and improper treatment

The enforcement action we took:

Condition of registration imposed.

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 Regulation 13(1) Safeguarding service users from abuse and improper treatment. HSCA RA Regulations 2014. Service users were not always protected from the risk of abuse and improper treatment.

The enforcement action we took:

Condition of registration imposed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) HSCA RA Regulations 2014 Good governance. The provider had not assured appropriate systems and processes were in place to fully assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

Condition of registration imposed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) HSCA RA Regulations 2014.

Staffing. Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not been deployed.

The enforcement action we took:

Condition of registration imposed.