Sheval Limited

Heatherside House Care Centre

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

Summary of findings

Overall summary

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

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The service was a large, isolated setting without easy access to the local community. People lacked choice and control over their lives through their limited knowledge of opportunity and limited staffing levels in the service. The model of care was institutional and was not person centred.

Staff did not have the right skills or knowledge to provide person centred care that was based on people's individual wishes for their preferred lifestyle. The lack of skills, knowledge and understanding of people's needs enabled ongoing acceptance of situations, such as behaviour that challenges, that compromised people's dignity.

The provider and registered manager did not always lead by example and had allowed a disabling, maternal culture to develop. The provider spoke disrespectfully about a person during the inspection and we made a safeguarding alert about this. Following the inspection, the provider stated they did not recall using the sentence. The safeguarding concern was closed as the safeguarding team was unable to evidence it. In addition, the provider and registered managers failure to follow current infection control guidance exposed people to risk of harm. Good practice regarding infection prevention and control was not being followed, particularly in relation to enhanced procedures required to protect people due to the pandemic.

Sufficient action had not been taken to protect people from the risks of incidents of behaviour that challenges. This impacted on the lives of people who challenged others, and those who witnessed these behaviours regularly.

Information about people's needs and incidents that occurred was not fully recorded and investigated. This meant the service was unable to learn from incidents that occurred and exposed people to ongoing risk.

Staffing levels were too low to offer genuine choice and opportunity to people. People were allocated minimal staff time each day and this impacted on their ability to access the community and develop their skills and interests.

The provider's recruitment procedures had not been followed to ensure new staff members were safe to work with vulnerable adults. Staff had been provided with some further training opportunities but could not describe how their practice had changed as a result. Training records showed some staff had not completed

training in infection prevention and control, or safeguarding.

Clear information regarding people's medicines was not available in all cases. There was no evidence people had been consulted in a way they would understand about taking more control of their medicines.

Risks to people had not always been assessed or defined clearly in their records. Some perceived risks were assumptions rather than based on assessment and resulted in further limitations for some individuals.

People had been asked if they were happy with the service and had made some small suggestions; however no consultation about the impact the environment had on people or the possible changes that could improve their experiences had been completed.

The registered manager and staff did not have a clear understanding of the Mental Capacity Act 2005 (MCA). People's capacity to make specific decisions had not been appropriately assessed. 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.

Information about how some people communicated was limited, which meant their needs were not fully understood. Information provided to people was not always provided in a format that was tailored to their needs.

People's care plans did not always use respectful language and we found some examples of people's dignity not being promoted. People did not always receive the right support to increase their independence.

The culture in the service did not value people's differences or focus on ensuring people had equality of opportunity within the service and the community. Observations during the inspection and records of how people spent their time showed people did not live a similar life to that of any other citizen. People were given basic options and choices but were not routinely offered or encouraged to try new or different things to increase their ability to make informed choices. This meant people chose the same options that had been offered over a long period of time.

People spent most of their days in the service doing repetitive activities, which although meaningful to the person in the context of the limited opportunities available to them; did not assure us each person was living a full and meaningful life. There was no evidence people were given real opportunities to be part of their local community.

The provider and registered manager had not taken the opportunity, since the last inspection, to implement effective change to ensure the service met regulations, reflected best practice and offered improved outcomes to people. They had relied on external bodies for guidance but had not understood the reasons behind the changes they were making. As a result, the culture in the service, staff ability to implement best practice and the opportunities offered to people remained poor.

People did not raise any concerns about the service. They told us they felt safe and enjoyed the things on offer. Relatives and professionals on the whole provided positive feedback about the service, the staff and the registered manager; however, this was not reflected in the findings from our site visit or in the records we reviewed.

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 inadequate (published 11 March 2020). Since this inspection, the registered manager has been sharing fortnightly updates of the actions taken to improve the service.

At a comprehensive inspection in March 2017, we found ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included breaches of Regulation 12 (Safe care and treatment), 17 (Good governance), 18 (Staffing) and 19 (Fit and proper persons employed). We asked the provider to complete an action plan to show what they would do and by when, to make improvements. We also served a warning notice on the provider and on the registered manager which required improvements to be made, within six months.

In December 2017, we undertook a focussed inspection to check whether the service had addressed the concerns in the warning notices. At this inspection we only looked at the Well-led domain. We found that the requirements of the warning notice had not been met and there was still a breach of Regulation 17. Following the focussed inspection, we met with the provider to discuss how they were going to meet the requirements of the warning notice and improve the service to ensure that they were good in all domains.

At our inspection in November 2018, we found the quality assurance and governance arrangements for the home were still not sufficient to ensure people received safe, effective care. We found breaches of regulation 11 (Consent), 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing). Following this inspection, the provider submitted an action plan stating how they would make the required improvements. The service was placed in 'special measures'.

In May 2019 we completed a comprehensive inspection and found the provider had not made enough improvements. We found continued breaches of regulations 11 (Consent), 12 (safe care and treatment), 17 (Good governance) and a breach of regulation 9 (Person Centred Care). Following this inspection, the service stayed in special measures and we took action to remove the location from the provider's registration.

At our last inspection in January 2020 we found the provider had still not made enough improvements. We found continued breaches of regulations 9 (Person Centred Care), 11 (Consent), 12 (safe care and treatment) and 17 (Good governance). We also found breaches of regulations 10 (Dignity and Respect), 13 (Safeguarding service users from abuse and improper treatment) and 18 (Staffing).

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

Why we inspected:
This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Enforcement
We have identified breaches in relation to person centred care, dignity and respect, the Mental Capacity Act 2005 (MCA), the safe care of people, staffing, safeguarding service users from abuse and improper treatment, the governance of the service and the failure to notify the commission of an injury to a person.

Please see the action we have taken at the end of the report.

Follow up
The overall rating for this service is 'Inadequate' and the service therefore remains 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.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Heatherside House Care Centre

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was completed by two adult social care inspectors and an assistant inspector.

Service and service type
Heatherside House Care Centre 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
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 reviewed information we had received about the service since the last inspection, including action plans submitted by the registered manager to the commission. We also sought feedback from the local authority quality team and spoke with the registered manager about

changes made since the last inspection. We used this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and one relative about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, senior care workers, care workers, activities co-ordinator and a member of the domestic staff. Some people could not easily communicate their views of the service, so we observed how people interacted with staff and how people spent their time. We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A range of records relating to the management of the service, including policies and procedures were also reviewed.

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.

After the inspection
We spoke with four relatives by phone and received feedback from three relatives and four professionals by email. We also requested and reviewed further information including people's care records and records relating to the monitoring of 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 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
At our last inspection the provider had not ensured staff had enough information and guidance to support people's behaviour and safety. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 12. People were still at risk because the provider had not ensured systems and staff skills were sufficient to support people to reduce episodes of behaviour that challenges.

● Limited action had been taken to understand the frequency and impact of incidents in the service. People continued to have a significant number of incidents of behaviour that challenges. From January 2020 to September 2020, records showed an average of 4.7 incidents of behaviour that challenges had occurred each month involving 11 different people. The registered manager had signed records describing each incident, but when asked told us, "We have only had ongoing behaviours with one person, and he has contact with the IATT team (Intensive Assessment and Treatment Team)." The registered manager had failed to recognise the level of incidents that were occurring, and the number of people affected.
● There had been no improvements in how people were supported to reduce incidents of behaviour that challenges others, since our last inspection. A published review of practice completed following the closure of Winterbourne View, found behaviour that challenges is reduced by better meeting people's needs and increasing quality of life. There was little evidence to show changes had been made to improve people's quality of life. Some people had positive behavioural support plans. However, these did not reflect best practice and focused on short term needs, describing what support strategies were already used rather than identifying any proactive strategies.
● Best practice is that reviews in relation to behaviour that challenges should look at all aspects of people's lives so staff can gain an understanding of why the person uses these behaviours. There was no clear system in place to review for example, the effect of the environment on people, or their routines or how they spent their time. This meant additional strategies had not been identified or tested following recent incidents. The registered manager confirmed new approaches had not been developed or trialled and told us, "If it's a behaviour that's happened before, we're already looking at distractions and activities." However, there was no data or evidence to show these were successful approaches. This increased the risk of ongoing incidents of behaviour that challenges in the service.
●There was a culture in the staff team that saw the person as being at fault for their behaviour. One person sometimes got anxious and used equipment in their room to show their anxiety. The registered manager told us, "[…] knows the electrical equipment is just an excuse for the behaviour." This did not show a focus

on trying to understand people or on supporting them to manage their behaviour better. Another person sometimes ate food it was unwise for them to eat, due to a medical condition. An update in their care plan included, "[…] has said that this is wrong and that he shouldn't be eating them but did get upset when asked." It wasn't clear how this helped staff support the person with this difficult area in their life. This did not reflect a culture of positive support for people with behaviour that challenges but increased the risk of reoccurrence.

● Information recorded suggested people were not always treated in a way that upheld their rights. Several records noted staff had told people their behaviour was 'unacceptable'. Following an incident of behaviour that challenges, a staff member had recorded, the person was "safely removed from the dining room and escorted to his room." Staff told us staff would not have touched the person however, another incident form for a different person stated, "[staff member] sent [person] to their room." The registered manager had signed these forms without querying the language being used or what had happened. This showed a poor understanding of the management of behaviour that challenges.

●No consideration had been given to people who were affected by others exhibiting behaviour that challenges. Right support, right care, right culture highlights the importance of an environment that does not feel impersonal and intimidating, will not feel institutional, maintains people's dignity and privacy and meets people's sensory needs and preferences." However, due to the ongoing incidents of behaviour that challenges, the environment could at times feel intimidating and affect people's sensory needs. There were times during the inspection when people were shouting, and this had a visible negative impact on others. One person told us another person's behaviour concerned them and told us, "Sometimes I have to shut the door."

●People had access to information about safeguarding and this topic had been discussed during residents' meetings. However, no information had been provided on how to raise concerns outside the service. This meant there was a risk that people would not know how to raise a concern externally.

● Staff we spoke with understood how to report any safeguarding concerns; however, the service's training records showed two domestic staff, two care staff and the cook had not completed safeguarding training. This meant there was a risk they may not have recognised safeguarding concerns. Safeguarding training had been booked for December 2020, however the service had not provided guidance to staff about safeguarding people, to ensure they understood their responsibilities, whilst awaiting the official training. This meant some staff would have been supporting vulnerable adults for several months before completing the training.

The provider had not ensured systems and processes in the service protected people from harm and reduced the risks to them. This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the behaviour of the provider's director exposed one person to 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.

● At this inspection, the same director commented in front of a person, "He does smile you know. Though I don't know if it is just because he is trying to open his bowels." The director's language and behaviour were highly inappropriate, increased the likelihood that other staff would see this as acceptable and treat people in a similar way and increased the risk of the person being abused. As a result, we made a safeguarding alert to the local authority. Following the inspection, the provider made a statement saying they did not recall using the sentence and would not speak in such a way about a resident or any individual. The safeguarding alert was closed as it was not possible to evidence the concern.

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

●People told us they felt safe at the service and relatives told us they felt their family member was safe. A professional who had supported a person to move into Heatherside as a short term, emergency placement told us they felt the person was safe and had been enabled to be as calm and settled as possible.
Learning lessons when things go wrong

At our last inspection the provider had failed to ensure incidents were properly recorded meaning it was not possible to identify patterns and trends in people's behaviour. This exposed people to risk. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

● Despite the implementation of some new documentation, and accidents and incidents being reviewed on a monthly basis by the registered manager, there was still little evidence of learning when things went wrong. Systems to identify triggers for people's behaviour, what worked well and what could be improved, were not effective. Published guidance had not been followed and incident records were not completed fully or consistently by staff. The trigger and duration of the behaviour were not always recorded, and the outcome of the action taken was rarely included. The registered manager had signed the documents but had not addressed the lack of detail. This meant it was not possible for patterns or trends in behaviour to be easily identified. The lack of clear leadership in relation to completing incident records, and the failure to fully investigate incidents, exposed people to ongoing risk of harm.
● New staff debrief forms had been introduced and were completed after incidents of behaviour that challenges. However, where some learning was identified following incidents, it was not shared effectively so similar incidents could be prevented. The registered manager told us a staff member had successfully used distraction techniques with one person when they became anxious. However, this approach was not used to support the person when they showed challenging behaviour during the inspection.

The provider had failed to ensure incidents were recorded, investigated and learning identified. This meant people remained at risk of harm during future, similar incidents and was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had not ensured sufficient staff were available to provide a person-centred service for people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider remains in breach of regulation 18 (Staffing).

● Staffing levels were not calculated in a way that considered all of people's needs. The registered manager told us the tool they used to calculate staffing levels had been developed for an older people's service. The tool did not allow time to be allocated to people for areas of their life such as developing skills, emotional support or accessing the local community. Apart from people's care needs, the only other category on the tool was 'activities'. People were allocated minimal staff time for activities each day, ranging from 15

minutes to 60 minutes per day. This meant the tool did not reflect the real number of staffing hours required in the service.
●Despite recognising the staffing tool was designed for an older people's service, the registered manager also told us it showed they had more staff in the service than required. The tool calculated the service required a minimum of four staff per day and the registered manager told us they aimed to have five staff on duty. However, the rota from 12 October to 8 November 2020 showed that on ten days there were less than five staff working throughout the day, and on seven days there were less than five staff working in the afternoon. On three days the staffing levels were unsafe in the afternoon as they were below the minimum calculated as required by the dependency tool.
●The low staffing levels meant people did not have regular engagement from staff during the day of our inspection. The registered manager said, "I feel they get the support they require when they need it." However, we saw people who spent their day passively staring at their radio, playing with a remote control or wandering round the service. The registered manager told us many people were getting older and so did not want to do as much. However, most people living at the service were under the age of 70 and records of how they spent their time showed it was not like that of other citizens. Most people rarely left the service. The service did not operate in accordance with the principles of Right Support, Right Care, Right Culture.
● The service is in a remote location, approximately five minutes by car to the nearest shops, 15 minutes to the local town and 25 minutes to the nearest city. No-one was able to leave the service without staff support and 13 people were allocated less than 30 minutes a day for 'activities' which meant opportunities to leave the service were limited.

The providers failure to appropriately assess the service's staffing needs and ensure identified staffing levels were achieved both exposed people to risk of harm and limited their choices and freedoms. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At the last inspection we found no concerns with recruitment processes but at the inspection prior to that, we made a recommendation about recruitment. At this inspection we found the improvements had not been sustained. Disclosure and Barring Service (DBS) checks had been completed but a full employment history was not available for all recently recruited staff, and references had not been sought in compliance with the provider's recruitment process. There was no job description or record of interview available for one new member of staff. This meant we could not be assured the registered manager had checked they were suitable for the role.
●Professionals and relatives told us they had no concerns about staffing levels when they visited the service. One relative commented that they felt the continuity of staff at the service was a positive factor.
●The registered manager had employed a staff member to work on some evenings to enable people to have more choice at that time of the day. They reported supporting some people to cook and providing some wellbeing activities such as painting people's nails and hand massages.

Using medicines safely
At our last inspection the provider had not given people the opportunity to take control of their own medicines. They had also not ensured people's medicines records were completed and checked effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 12 (Safe care and treatment).

●There was no evidence people had been consulted, in a way they could understand, about different

options to take more control of their medicines. For example, whether they wanted to keep their medicines in a lockable cabinet in their own room. Two people's care plans said their long-term goal was for staff, "To encourage […] to take an active role in the management of his medications promoting independence and autonomy." There were no records showing how they had been consulted about these aims, or information describing what support they required to achieve this goal.

●Guidance for staff on how to support people with their medicines was not always clear. One person could have their medicines covertly (given without their knowledge, disguised in food or drink). This had been agreed with their GP. Their records advised the medicines were less effective when given with food, but no advice had been sought from a pharmacist to check if certain medicines were affected more or less by specific foods. A staff member told us they offered the person their medicines first before administering them covertly, but the person's care plan did not reflect this or provide guidance about what helped the person accept their medicines. No assessment of the person's capacity to understand the need for their medicines had been completed.

●Details of when people should take their medicines and what dosage were not always clear. When people were prescribed a medicine to be taken as required (PRN) there was not always a protocol in place directing staff when to administer it. Details to guide staff about where to apply people's creams were not always clear. People's medicines prescribed with a variable dose, were not always accompanied with guidance about what dose to administer; and staff did not always record on the Medicines Administration Record (MAR) what dose they had given the person. A MARs audit completed in September 2020 had identified issues about records in relation to prescribed creams and PRN Medicines. These issues had not been addressed or resolved and this meant the audit was of minimal value.

This formed part of the breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff received training and a competency assessment before being able to administer people's medicines. A plan was in place to ensure staff's competence was now assessed annually.

Assessing risk, safety monitoring and management

●People had risk assessments in place, however these did not always describe all potential risks to people. One person was unable to eat solid foods due to a medical condition. Staff told us the person sometimes ate food which made them sick, but they did not always tell staff. They told us they recorded whether they were aware the person had been sick each day. This information was not detailed in the person's care plan or risk assessments. A letter from the person's dietician requested, "Please can staff ensure that as much as possible they are observing when anything involving the feed/ feeding tube is being completed." This request and other risks relating to the use of the percutaneous endoscopic gastrostomy (PEG) were not recorded in a risk assessment. We saw the person alone in a lounge whilst using the equipment.

● Guidance detailing how to reduce risks to people was not always included in people's records. One person was assessed as at high risk of skin damage and prone to urine infections. However, no risk assessment had been completed in relation to these issues. The person's care plan about their skin did not mention they were at risk. A letter from a health professional in relation to another person's diabetes, stated, "[…] manages insulin himself. However, I note that he forgot to take his insulin this morning and admits to forgetting occasionally." There was no guidance in their records detailing the support they needed to reduce this risk. Following a review of a person's records in July 2020 the local authority has also identified missing information about risk mitigation.

●Staff did not always take the correct action to reduce risks to people. One person had a mattress to reduce pressure on their skin. They weighed 53.2kg but when we checked, their mattress was set for someone who weighed 91kg this exposed the person to risk of harm.

●Staff did not display a culture of positive risk taking to enable people to experience new things or increase their skills and independence. One person was at risk of choking and their risk assessment stated, "Staff to always strongly discourage […] from entering the kitchen, key pad fitted to the kitchen door, staff to make sure kitchen door is always closed. Keep door locked at all times sign." There was no evidence staff had considered ways for the person to be involved safely in other kitchen activities. Another person's shaving equipment was kept in the office. This had been raised at the previous inspection, but no action had been taken and the person's records still did not show why this was being done. When asked during the inspection, the person responded that they would like to have an electric shaver that they could keep in their room. Staff's approach to risk limited people's opportunities.

The provider had not ensured information about risks to people was used and recorded effectively to inform staff support. This formed part of the breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●A healthcare professional who supported people in the service who had epilepsy, told us their advice was sought in relation to safety aspects of people's care.
●There were arrangements in place to keep people safe in an emergency. The registered manager told us people's PEEP forms were kept in a file in the medical room.

Preventing and controlling infection
● People were not protected from the spread of infection. During the inspection, two members of the management team demonstrated poor practice relating to wearing PPE. We observed them in communal rooms where people were present and in an office with other staff, while not wearing surgical face masks. This is contrary to current guidance published by Public Health England on the management of infection control risk during the Covid-19 pandemic. These senior staff were responsible for overseeing the correct use of PPE within the service.
● Other staff members used reusable cloth face coverings instead of the correct surgical face mask. One staff member was supporting people to cook with only a visor and no mask. The staff member told us they had not received any infection prevention and control or food hygiene training.
● The training matrix showed seven staff members, had not completed or did not have up to date infection control training. The local authority had recommended in July 2020 that the provider should ensure infection control training was up to date and evidenced on the service's training matrix, however this had not been done.
● There was no evidence regular cleaning of high use areas such as door handles and light switches was completed. Cleaning staff finished working at approximately 2pm and care staff told us there were no formal cleaning responsibilities until night staff started work. An infection control audit completed by the registered manager on 17 September 2019 and a COVID-19 risk assessment/ contingency plan updated on 2 November 2020, did not prompt checks of staff use of PPE or highlight any gaps in cleaning activity. This placed people at risk of infection.
●The provider's infection control policy was out of date as it referred to previous versions of the regulations that were updated in 2014.

These failures to follow current infection control guidance exposed people to risk of harm and was a breach of the requirements of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the site visit we sent a letter of intent to take enforcement action against the provider and requested an action plan from the provider showing how these concerns would be addressed.

The registered manager engaged with the local Infection Prevention and Control Team and provided an appropriate action plan to resolve these issues. The evidence provided us with some reassurance. A follow up inspection was completed to check on infection, prevention and control. The further visit to check infection, prevention and control, found the issues brought to the attention of the provider had been addressed, and found no further concerns.

The provider had systems in place to check visitor's health before they entered the service and had accessed testing for people who had consented, and staff.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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
At our last inspection the provider had failed to ensure people's care was being delivered in line with evidence-based guidance. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

●The design and culture of the service still did not reflect best practice for supporting people with a learning disability. The service model, including the size and activities available, reflected a service for older people. The registered manager told us they were aware of the Right Support, Right Care Right Culture guidance, but could not give any tangible examples of any action they had taken as a result. The NHS England guide on service models states, "Capable environments are characterised by: positive social interactions, support for meaningful activity, opportunities for choice, encouragement of greater independence, support to establish and maintain relationships and mindful and skilled family/carers and paid support and care staff." This description was not reflective of the environment at Heatherside House because people's needs and choices had not been assessed or provided for, in line with best practice.
● There were still no plans describing possible changes to the physical environment, to align the service more closely to the principles of the Right Support, Right Care, Right Culture guidance. Plans to improve the service focused mainly on increasing and improving records, rather than on assessing and consulting people and other stakeholders about how the service could be changed to enhance their way of life and enable them to live as ordinary a life as possible.
● The registered manager was aware of a limited amount of best practice guidance for learning disability services. They were not aware of the closed cultures guidance published by CQC, even though the location and design of the service increased the risk of developing a closed culture. They told us they used online managers' forums for advice, and they received emails from Skills for Care; but could not detail any further guidance used to aid learning and inform improvements, such as the Skills for Care guide to improvement or the other best practice guidance referenced throughout this report.

People's care was not being delivered in line with evidence-based guidance. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At our last inspection the provider had not ensured people were supported to have autonomy or

involvement in the community. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 10 (Dignity and Respect).

● There was little change to the support people received since our last inspection, which meant their autonomy and independence were still limited. There was no drive to see people holistically or understand how their needs were interlinked. Systems to collect data to understand all areas of people's lives and how these affected them, either did not existent or were ineffective. For example, people who were diagnosed with autism did not have a sensory assessment, even though this is particularly recommended for those who use behaviour that challenges. This meant staff did not have the right information to support people to increase their autonomy.
● People's opportunities to increase their independence remained limited. The local authority had recommended in July 2020 that ways to develop people's skills should be considered, rather than accepting the status quo. Limited action had been taken in response to this recommendation, which meant people did not receive tailored support to develop every day skills such as managing money or their medicines.
● People had not been supported to find meaningful ways they could be involved in their local community. Their contact with the community was mostly limited to shopping trips or visits to cafés. These did not happen regularly and for some people, never happened. This meant people did not experience the best possible outcomes in their life, similar to those expected by an ordinary citizen

The provider had not supported people to develop autonomy or supported meaningful contact with the local community. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
At the last inspection we found the provider had not ensured staff had the correct skills, knowledge and competence to deliver best practice within the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 18 (Staffing).

●There were still gaps in the training staff had received. As described in the safe section of the report, some staff had not completed infection control training. The service's training matrix also showed four care staff had not completed food hygiene training. One staff member told us they had not completed any training since working at the service. This placed people at risk as staff did not have the skills necessary to meet their needs.
●The provider had not ensured staff had the correct training, skills and experience to provide support to people that was tailored to their needs. Some people had positive behavioural support plans in place, however proactive strategies had not been developed and staff had not received training in positive behaviour support.
● Staff told us they had completed more training but could not describe any impact it had had. Some staff had completed further training related to the needs of the people living in the service, for example, learning disability and behaviours that challenge awareness, autism awareness and equality and diversity; Activities provision and person-centred approaches were also on the service's training matrix but of 18 staff only three and six staff respectively had completed them. There were no tangible examples of how this training had

impacted on staff practice or increased people's quality of life.

The provider had not ensured staff had the opportunity to develop their skills and knowledge of how to meet people needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered manager told us one to one supervision meetings with staff were now more detailed. Staff told us it was easy to speak with the registered manager if they needed to and that they sometimes had small group supervisions whilst on shift. They also said communication about any changes to people's needs had improved.
●Relatives and professionals provided positive feedback about staff and told us they had the skills to meet people's needs.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection the provider had failed to ensure people had the opportunity to contribute to meal planning and cooking in a meaningful way. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some improvement had been made but the provider remained in breach regulation 9.

● Four recent records showed most people had made choices about what meals they would like. One person who did not use verbal communication or any other communication tools, was noted never to have made food choices. Their care plan noted they had a sweet tooth but gave no further information about likes or dislikes. This made it difficult for staff to consistently support the person with a choice of their preference. There was no evidence to show if staff were taking steps to help them become more involved.
● Staff did not ensure people's mealtimes were tailored to their preferences. A small kitchen area in the service was now used more by people who wanted to prepare their own breakfast, drinks or snacks and a small amount of people were sometimes supported to cook a meal of their choice; but on the whole people ate the same meal which was prepared for them by a cook in an industrial type kitchen. People ate at a time decided by the service and were not routinely involved in buying or cooking the food. Observation records completed by the registered manager and staff had not highlighted any aim for people to be more in control or involved in planning and preparing meals.
● Some people's care plans mentioned that they needed to be supported to eat a healthy diet; however individualised information about what this meant for each person and how staff could support and encourage them to eat a balanced diet, was not included.

The provider had not ensured people had full choice and control over their mealtime experience. This contributed to the continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● As detailed in the safe section of this report, staff did not always fully understand how to manage risk in relation to food and mealtimes. In addition, we found one person who needed a pureed diet to manage choking risks, had recently eaten a cheese sandwich and sausage and chips from the chip shop. Whilst safe, if pureed with liquid, it was unlikely these meals would have been palatable in a pureed form.
● One person told us the food was lovely and relatives told us their family members were positive about the meals they had. The registered manager told us people had given positive feedback about the food via questionnaires and resident's meetings. Staff told us the cook was knowledgeable about people's likes and dislikes.

Adapting service, design, decoration to meet people's needs
At our last inspection the provider had failed to ensure the environment was tailored to meet people's needs and preferences. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9 (Person Centred Care).

●No consultation about the environment had taken place in a way people could understand and that promoted informed choice. Minutes of resident's meetings showed the registered manager used open questions, such as whether people wanted any changes to the service, to gain feedback about the environment. These would be difficult for people to answer without individual support to think how the environment affected them or to understand the possible changes they could request. No assessment of the environment had been completed to consider how it impacted on people's wellbeing in response to the numerous incidents that had occurred since our last inspection.
● People lived together in one large group with one staff group and access to the same garden. Laundry, cooking and most activities used communal facilities. The main kitchen was an industrial style kitchen with a serving hatch into the dining room. There were several notice boards around the home displaying information. Some of this was in easy read format with pictures but other information displayed was wordy with complex language. Equipment to move people was stored in a communal bathroom and people's medicines were stored in a separate room, not securely in people's rooms. There were three lounges, one of which was in the middle of the premises and was a thoroughfare between the office and some bedrooms. Staff continually passed through this area which meant it was not conducive to TV watching or quiet relaxation. The registered manager told us people chose where to spend their time.
●The service design did not reflect best practice and there were limited plans about how this could be achieved. People were not regularly offered the opportunity for positive social interaction and some people received little engagement or support during the inspection. Records showed most people did the same thing every day. Some people were completing some tasks more independently, but there was no clear plan to support people to gain further independence. There was very little consideration of how people could develop their own relationships outside of the service.

The provider had not ensured collaborative assessments had been completed to identify people's needs and preferences in relation to the design of the service. This formed part of the continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●A courtyard in the middle of the service had been tidied up since the last inspection. A member of staff told us people had been involved in planning and completing it and had enjoyed being involved in the project.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider had not ensured that conditions on authorisations to deprive people of their liberty were being met or that consent was sought for care provided. This was a repeated breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

●There was no clear understanding of the MCA, DoLS and Best interests process in the service. This is an ongoing concern that could expose people to significant risk. One person was described in their records as having 'no capacity' to make decisions but their records also showed they were able to make decisions about whether they wanted to eat and what they wanted to wear. An MCA assessment completed for them showed all questions answered with exactly the same response. This was that the person was unable to make a decision, so all decisions would be made in their best interests. This did not evidence their capacity or decision-making ability but suggested the conclusion had been reached before the assessment had been completed. The person was sometimes administered their medicines covertly and was prevented from going into the kitchens. No MCA assessments had been completed about these restrictions. A social work professional who had reviewed other people in the service told us the lack of understanding of MCA had stood out to them.
● The deprivation of liberty safeguards were not fully understood by the provider or registered manager. The service had applied for a DoLS on behalf of one person regarding leaving the service, but it had been rejected as they were deemed to have the capacity to understand the risk involved. The registered manager told us they had made the application because the person did not want to go out on their own. They had not understood that, as the person had the capacity to make the choice, a DoLS was not required. Another person's care plan recorded, "Due to me living in 24 hour residential care, a DoLS application has been made." This showed a lack of understanding of the reason for DoLS authorisations.
●One person had a DoLS in place because they were restricted by a lap belt on their wheelchair and were deemed not to have the capacity to understand the risk to them. However, a risk assessment about an armchair they used without a lap belt stated, "[…] has consented to sitting in it without a lap belt and is aware he is more at risk of falling without one." The risks were similar and yet the service had come to different conclusions about the person's capacity to understand them. This issue had been raised at the previous inspection.
●In the previous report we highlighted a conflict of interest as the provider or registered manager was involved in a best interests' decisions in relation to them looking after people's monies. A professional fed back that they had recently identified a similar conflict of interest in the service. They told us this should have been reviewed much sooner. However, the provider was still an appointee for a different person's finances, and this remained a conflict of interests.

The provider had not ensured the registered manager and staff understood the principles of the MCA or how to uphold people's rights. This was a continued breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●People's records contained information about their health needs; however information about how these

health needs affected them and what support they needed from staff was limited. This was highlighted as issue by the local authority in September 2019 and in July 2020. One person's weight was significantly impacting their health and wellbeing and they had told a staff member it was limiting their choices. A referral had been made to an external professional, but no information was recorded in their care plan about how to support them in this area. Records showed they had been regularly supported to engage in baking activities which involved eating high calorie food. There was no evidence available to demonstrate ongoing action to support the person to lose weight and improve their health.

● Information about how to recognise someone was ill was not always included in their records. One person's care plan stated that due to their communication needs, they relied on staff to recognise how they were feeling. Their behaviour support plan explained they might use behaviour that challenged when they were feeling ill. However, there was no information to help staff recognise when the person was feeling unwell. Following the inspection, the registered manager told us they used a record called the Abbey Pain Scale, which is used for people who find it difficult to communicate. It asks generic questions about the person's demeanour to identify if they might be in pain. People's care records did not describe how staff would know when to use this tool. This meant people were at risk of any illnesses not being identified promptly.

● Details of the support people required to maintain their oral hygiene was not always clear. One person's care plan stated, "I only have a few of my own teeth that are in very poor health." It also noted the person often declined oral care and often had oral infections. The care plan did not describe the best ways to help ensure the person engaged with oral care, or detail different methods that had been tried. It also did not describe how to recognise when the person had an infection.

●People's care plans did not contain a holistic assessment of their health but mainly focused on medical issues. One person's falls risk assessment noted, "[…] can be reluctant to move, encourage and promote exercise." This information or how to encourage them, was not in their care plan. Other people's care plans contained little or no information about what support they needed to remain fit and active.

The provider had not ensured staff were doing all that was reasonably practicable to mitigate risks related to people's health. This contributed to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Healthcare professionals gave positive feedback about the support staff provided to people regarding their health. They said staff contacted them for advice, referred people appropriately and followed guidance provided.

Staff working with other agencies to provide consistent, effective, timely care

●People benefitted from a staff team who had good relationships with health and social care professionals. Professionals confirmed staff worked well with them and had positive relationships. They told us the registered manager and staff communicated well with them and regularly. They also said staff sought their opinion and involved them in best interests' decisions.

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 the last inspection this key question was rated as 'requires improvement'. At this inspection this key question remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
At our last inspection the provider had not ensured people's care was designed to meet all their needs and preferences. This was part of a continued breach of regulation 9 (Person Centred Care).

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

●Observations and information recorded of how people spent their time, did not evidence people were well treated and supported. During the inspection one person was on their own in a communal lounge for most of the day, playing with a remote control. Although the TV was on, they showed little interest in the programme. Another person spent most of their day in their room with their radio on, staring directly at it. When we asked how this person spent their time, they responded, "Eating, drinking, sleeping." Staff were not observant of potential discomfort people were experiencing and were not proactive in offering solutions. For example, one person was seen sitting close to and directly below a television that was mounted on a wall. In order to see the screen they had to lean back and crane their neck. No staff member approached the person to ask if they would be more comfortable sitting in a different location. The lack of skill within the staff team to identify when people could achieve a better outcome impacted on people's lives.
●People's disabilities and ages were used as barriers to them being able to have the same life as any other citizen. The culture in the service did not value people's differences or focus on ensuring people had equality of opportunity within the service and the community. The registered manager told us staff had attended equality and diversity training which "touched on human rights", but no further action had been taken to help ensure people's rights were promoted. One staff member told us, "The last training was equality and diversity. No impact, always it's just the words, some had moved on. I've always been aware of it." One person used a wheelchair and could not use the small kitchen other service users used as it had no work surfaces at an accessible height.
●People were not supported effectively by staff to explore or communicate any preferences related to protected characteristics. People's care plans included a section for people's sexuality. This information had not been consistently recorded and where information was available, it did not generally relate to sexuality or demonstrate these subjects had been discussed or fully considered. One person was unable to communicate verbally and did not use any communication tools. However, their spirituality care plan stated, "Currently I express no interest in attending church. If I express the desire to attend church or see the vicar, then staff provide the transport or arrange a visit for me." There were no systems in place to enable or support this person to express their wishes in relation to these or any other topics.

●Some people were supported to maintain contact with their family, but we were concerned this was not the case for all people. Right support right care right culture highlights the importance of people being enabled to maintain regular contact with their family members. Following the inspection, the registered manager confirmed six people did not have contact with relatives. The opportunity to develop alternative relationships had not been offered to each of these people.

The provider had not ensured people's care considered all their needs and preferences. This was part of a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People told us the staff were kind and relatives confirmed they thought their family member was looked after well. Comments included, "[My relative] has been looked after safely and to a very good standard, and has been shown a lot of kindness", "Staff are friendly and they all obviously know […] and treat them with affection and dignity" and "I know that most of the staff team are of long standing and have positive and warm relationships with the people they care for and support."

Supporting people to express their views and be involved in making decisions about their care
At our last inspection the provider had failed to ensure people were provided with the correct tools and support to communicate effectively. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9 (Person Centred Care).

●People were not always able to easily express their views or feelings and additional support had not been provided. People's care plans did not adequately describe their communication skills to enable staff to understand them well. For example, some people's care plans described how they would use behaviour to show pain or frustration. However, the registered manager told us the service had completed no further work regarding people's communication needs and confirmed people had not been offered the opportunity to have an independent advocate. This meant people may not have been able to express their views fully.
●People's views were not always sought before decisions were made on their behalf. A resident's meeting was used to tell people keyworker meetings would be taking place, how and why. There was no evidence people had been consulted about these meetings so they could be tailored to people's wishes. One person had been very upset about the death of a member of staff who had been their keyworker so a decision had been made that they would not have another keyworker. A staff member told us, "Everybody is her key worker. Don't want her to become too attached to one member of staff. She was very upset when her keyworker died." They had not considered the person might want to experience the close relationship they had previously had. Their relative told us, "I am not certain [my relative] has had the same relationship with a new carer." Staff had taken away the person's opportunity to express their view and make their own decision.

The provider had still failed to ensure people were provided with the correct tools and support to communicate effectively. This forms part of a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff had helped people understand the pandemic and the related lockdowns.

Respecting and promoting people's privacy, dignity and independence

At our last inspection we found the provider had not ensured people were always treated with dignity and respect and their independence was not supported. This was a breach of regulation 10 (Dignity and Respect). At the previous inspection we had made a recommendation about how people's privacy, dignity and independence were promoted.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 10 (Dignity and Respect).

●People's care plans and the support they received did not always promote their dignity. One person was described as being able to use the toilet but chose not to do so regularly, as a result they used continence aids. Their care plan did not describe how staff encouraged them to maintain their independence and dignity. Language used in people's records did not always promote their dignity. One person was still described as "roaring". The person did not use verbal communication and was also described as "mute" in their care records. This showed staff did not consider whether the language they used to describe people was respectful.
●People's privacy and dignity was not always considered. The improvement plan for the service noted as a positive achievement that two people now had laundry baskets for their room. The other people living in the service did not have their own laundry baskets. This was not respecting their privacy and dignity and was reflective of institutional practice.
●People were not always provided with the support they needed to develop independence. Professionals mostly told us people were supported to develop their independence, however, our observations and records in the service showed this was limited. People's care plans frequently noted the person's aim was to become more independent or take more control in that area of their life but lacked detail to guide staff on how to support the person to achieve the goal. Some people were enthusiastic about the opportunity to prepare food and drinks for themselves but there were no plans in place to help these individuals develop their skills further. Staff did not have the time necessary to work alongside people at their own pace while learning new skills so blanket approaches were taken to how support was provided. Requests for support to increase independence were not always met. One person wanted to be supported to cook a meal but records showed they had not been supported to achieve this aim.
● The registered manager gave an example of how one staff member had worked to increase a person's confidence in leaving the service by building up trust and taking the time to discuss any concerns and make plans. However, there was no evidence this approach had been used to benefit anyone else in the service
● A professional told us they thought an improvement to the service would be to develop and promote independence, focusing on achieving and maintaining goals agreed with the person.

People were still not always treated with dignity and respect and their independence was not supported. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●A healthcare professional told us they observed staff treating people with common courtesy and respect.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure people's needs and preferences were met in a way that maximised the choice and control they had over their life. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

● The level of choice and control people had over their lives was limited because records lacked detail to guide staff how to support them. Some care plans described aspects of people's routines, for example getting up or going to bed, but others lacked specific detail about individual's preferences and the support they required. For example, one person's care plan gave very little information about their preferred personal care routine, what they could do for themselves or what products they preferred to use. People's care plans did not detail how staff could support them to develop skills to increase the control they had over their lives.
● There was little evidence of meaningful consultation with people to ensure staff understood their preferred lifestyle. People's care plans included monthly records to capture their hopes and dream. They did not reflect the hopes and dreams of other citizens but reflected short term goals which were limited by people's experiences. They included, "shopping", "get an ice cream" and "play on my ipad". One person consistently had the same three 'hopes and dreams' activities recorded every month. These had not changed since our previous inspection and suggested no action had been taken to encourage them to try new experiences.
●Information had been recorded in people's care plans to guide staff on what helped someone have a good or bad day, but these reflected very low expectations. For example, people's 'what makes a good day' recorded things like, "moving around", "looking around", "talking to people". This did not reflect an enabling culture designed to maximise the choice and control people had over their lives.
●People's preferences and choices were not always sought during reviews of their records. Not all people were involved in the review process and the registered manager told us people's relatives had not been involved. One person's records stated, "I'm working on this: Accepting new people and new experiences, having a better sleep pattern, knowing when my actions upset or distress those around me." There was no indication the person had been consulted about these goals, no additional detail describing how they would achieve them and no evidence to demonstrate any success.
●Staff did not have a consistent understanding of people's preferences. One person's care plan stated they

liked country music. One staff member told us the person liked any music but another staff member told us music made them a little agitated. A relative of another person told us when they visited their family member, they drove for hours to all the places the person wanted to see, however there was no evidence the service had supported this person to have similar experiences.

● People had not been supported to widen their knowledge of available options which severely limited and restricted their choices. The registered manager told us, "People do know there are other options. They are involved in residents meetings and keyworkers meetings and we discuss opportunities." However, records of resident's meetings showed people had been asked open questions about what they would like to do. This relied on people being able to express their views and having prior knowledge of a wider variety of options. People, their relatives and professionals told us people were able to make choices but gave examples of basic day to day choices that were mostly limited to the confines of the service. Work had not been undertaken to enable people to identify new experiences they might enjoy and to enable informed choices to be made.

● Staff were not always responsive to people's requests. Some people told us they were asked about their preferences and that staff listened. However, at a resident's meeting, one person said they would like some Christmas decorations up. The meeting minutes show the registered manager, "explained this would happen nearer to Christmas." There was no discussion about whether everyone else wanted decorations now, or whether people would like to start planning for, making or buying some decorations. There were no records of a subsequent conversation when people had been able to decide when to put up the decoration and decorations were not present on the day of our inspection. This meant people's views were not always listened to or respected.

● People did not always have choice and control over changes to the service. A key worker system had recently been introduced but people had not been involved in the design of the role. The registered manager told us meetings with keyworkers helped ensure people had informed choice. One staff member told us they thought keyworker meetings should be approximately twice a year, which would not help promote informed choice. The record of a keyworker meeting for a person who did not communicate verbally, just reiterated what was already in their care records. There was no evidence different approaches to communication had been tried to gain their views or preferences. During another key worker meeting a person had reported a concern about the impact their health was having on their choices. Although the information had been recorded staff had not supported the person to improve their health to increase their options.

The provider had not supported people to have choice and control of their lives. This forms part of a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to ensure people's care was designed to achieve their preferences and meet their needs. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

●The service still did not offer people the opportunity for genuinely meaningful activity that reflected the same opportunities of any other citizen. Social Care Institute for Excellence (SCIE) COVID-19 guide for care staff supporting adults with learning disabilities or autistic adults states, "People with learning disabilities

and autistic people have the same rights as the rest of the population to live purposeful lives as active members of families and communities. At its best, social care promotes and upholds these rights, so that people with learning disabilities and autistic people can enjoy lives that are rich, fulfilling and fully included in society." The culture in the service was institutionalised and did not reflect this ethos. People received little support to engage with individual pastimes and interests but instead were mostly offered communal "activities" within the service. People had not been supported to engage with tasks and hobbies similar to other citizens, such as shopping, education, attending a gym or library or being part of the local paid or voluntary workforce. The provider's service user guide said the service would, "Encourage service users to grow and evolve towards their full potential." However, we found no evidence to support this claim. Staff had not discussed education or work with anyone living in the service, so no further action had been taken in this area and people's lives continued to be limited.

●Our observations and conversations with people indicated people did not have enough to occupy their time. We observed people in the service spending large parts of the day not involved in any pastime or activity. They spent long periods disengaged and passive. We observed two people who had very little staff interaction throughout the day but were staring or doing repetitive movements. For example, one of these people spent most of their day in their room with their radio on, staring directly at it. Another person spent the majority of the day walking aimlessly or unoccupied in communal areas. Several times he approached inspectors, taking their arm and leading them around the property or outside. In a central corridor several people spent time just standing near the front door with no aim or focus. Staff regularly passed these people but did not try to engage them in conversation or any activity.

● People's records reflected a lack of meaningful engagement. One person's daily notes for the morning of 27 October stated '[…] chose to sit in the chair by the front door and could be heard laughing to himself. […] then attended lunch." This did not reflect any meaningful engagement or activity. Their care plan listed aims that included them having "a full and varied appropriate programme of structured activities that will stimulate and alleviate boredom" and "a programme of activities that will motivate and inspire." These were the same aims as at the previous inspection but still no action had been taken to achieve them. The goals recorded for them every month were to go for a drive every day, walk round the garden and play catch with a soft toy. These were also the same as the last inspection. They rarely achieved all three each day but spent a lot of time wandering round the service or sitting watching people and staff. Other records of people's activities included "holding onto her wool", "independent", "watching the news", "chatting about the weather" and "time in room", which suggested people were not engaged in meaningful activities. Most people spent the majority of their time in their rooms or watching television.

●There was no process for staff to use information or their knowledge to suggest new and creative experiences that would enable people to have a more fulfilled life. The registered manager and staff told us people had opportunities but sometimes declined to take part, so they now documented what had been offered and any refusal to participate. This information was not reviewed to improve the type of opportunities available to people. As a result, people's lives were not improved. A professional fed back that some of the activities in place appeared quite monotonous and repetitive and very 'samey'. They suggested it would be good for the service to tailor activities to challenge people's social and independence levels, to think creatively and provide more experiences.

The provider had not ensured people were provided with sufficient support for staff to identify and meet their preferences. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had not ensured service users were supported to develop or maintain autonomy, independence or involvement in the community. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 10.

●The provider was not following guidance in relation to Right support, right Care, right culture which highlighted the importance of services being located so people can participate in their own local community and not in secluded grounds or geographically isolated. The service was in secluded grounds and geographically isolated and no action had been taken to minimise the impact of this on people or to support people to develop links with the local community.
● Everyone living at the service relied on staff to take them out. People sometimes went to the shops or to a café but this was the limit of their involvement in their community. Some people were particularly isolated and had little, to no contact with the community. One person was not supported or encouraged to use local shops, or even external services like a hairdresser. They went for a short drive each day but spent the rest of each day in the service with limited engagement in any activity or pastime. Records of people's activities between 16 October 2020 and 2 November 2020, showed most people spent most days in the service and that people rarely went out. When we asked how people were involved in their local community the registered manager gave examples of entertainers visiting the home.
●Staffing levels and number of vehicles available, limited people's options. The registered manager told us there were no barriers to people going out. However, staff told us, "Sometimes with the younger ones, transport can be an issue. Can't always go out in one go so they might have to wait, that is life. The vehicle is the barrier not staff availability" and "There is not enough staffing, for spontaneous trips out. They are planned in advance." A relative added, "The home doesn't have staff to take them out all the time. Don't know what you can do about that. They have a bus, but they can't go out all the time." There was a general acceptance in the service that this was acceptable.
●At the time of the inspection, there were 18 people living in the service and between three and six staff working during the day. This meant it was not possible for people to go out for any length of time unless they went out in groups. This restricted people's opportunities to take part in individualised pastimes or be part of their local community.
● People did not receive the support they required to develop independence or autonomy. One person asked each month to go shopping, another person had requested support to cook a meal and a third person had said they wanted to wash cars. There was no evidence staff had supported people to achieve these goals. Cooking had been highlighted at a recent resident's meeting as something people wanted to do more of. However, an additional monetary charge had been introduced by the service for joining cooking, entertainment, or bingo activities. This did not reflect an inclusive person-centred culture aimed at providing people with the best outcomes.

The provider had not ensured service users were supported to develop or maintain autonomy, independence or involvement in the community. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Relatives and professionals told us people were offered choice.

Meeting people's communication needs
At our last inspection the provider had failed to implement appropriate systems to enable and support people to make decisions in relation to how their care was provided. This was a continued breach of Regulation 9 (Person Centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●Records about people and information in the service were not routinely produced in formats that would be easy for people to understand. There was no evidence staff had developed accessible records, for example easy read, to help people understand the records about them. A form to explain the test for COVID -19 to people and gain their consent had not been produced in a format that would be easy for people to understand. The registered manager had used a resident's meeting to tell people that if they wanted information in a different kind of format, they would be supported with this. They did not use the opportunity to explain the options to people, try new communication approaches or ask if anyone would like to use these options.
●Some information was recorded about how staff should communicate with people to aid their understanding. However, it lacked the specific details and techniques used by staff. A staff member told us staff used facial expressions, eye contact, touch and pointing to objects to communicate with people but information about how to use this successfully with each individual was not recorded. This increased the risk of communication with people being inconsistent.
●People's care plans did not adequately describe their communication skills, such as specific expressions, gestures or behaviours they used. One person's care plan stated the person was "reliant on staff to identify difficulties" and this was a "high-risk area". However, it did not give a clear description of the person's communication abilities, the support they required or how to interpret their body language. A goal was recorded in their care plan which stated, "To enable […] to develop skills that will enhance their communication abilities. To prevent any deterioration of skills already possessed." There was no guidance within this care plan on how this goal should be achieved. This failure to recognise and develop people's differing styles of communication adversely impacted on their ability to communicate their needs.
●Some people showed their emotions through their behaviour rather than words. Best practice guidance for managing behaviour that challenge refers to the importance of understanding this behaviour often indicates an unmet need. Staff did not always see people's behaviour as a means of communication and there were limited attempts to understand what was being communicated. We observed one person sitting in a communal lounge for most of the day with the television on but playing with the remote control and doing repetitive hand movements. Throughout the day staff did not attempt to engage with this person in any meaningful way. In the afternoon of our inspection visit the person had an altercation with another person which caused the victim significant distress. Staff did not engage with the person in an attempt to understand why they had exhibited this behaviour.

The provider did not have appropriate systems in place to ensure information was provided in a way service users could understand. This failure forms part of the continued breach of Regulation 9 (Person Centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The provider's service user guide was out of date. It had been reviewed in February 2020 but advised people to contact a previous regulator that had not existed since 2009. It also advised that prior notice of inspector's visits would be displayed in the service, even though inspections are usually unannounced.
●People told us they could talk to staff members if they had a concern and that they would be listened to. The registered manager told us no complaints had been received.
●Professionals and relatives confirmed that any concerns they had, had been addressed quickly.

End of life care and support

●People had end of life care plans in place. Where people were able to express a preference. These had been recorded; however for those unable to clearly share their views, no further action had been taken to help ensure personalised plans were in place.

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 inadequate. At this inspection this key question remained the same. 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

At our last inspection the provider had failed to ensure sufficient oversight and governance to deliver a person-centred service which was inclusive, empowering and supported people to achieve good outcomes. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

●It was evident the provider and registered manager still did not understand the improvements required to ensure the service was meeting regulations and best practice. The same concerns highlighted by CQC through several inspections, and by the local authority over several years, had not been rectified. The provider and registered manager believed they were delivering a good service to people and they believed it was the evidence of this that was lacking, so there had been a focus on paperwork. There was little evidence to show this focus had improved outcomes for people, and there was limited evidence available, both from records and inspectors observations to demonstrate the service was providing person centred care.
●People did not have a fulfilled and meaningful life. They were not encouraged to maintain or build new social connections, to learn new skills or contribute to the community. People said they were happy living in the home, but they had developed low expectations for their lives and had a narrow experience of the real opportunities available to them. People did not receive support tailored to their needs and no time had been taken to identify how they could develop the skills to achieve more.
●In a staff meeting the provider had used, "cooking, a tuck shop, quiz and trips to the shop" as examples of a meaningful day. This was not in line with best practice guidance and evidenced a lack of understanding. Building the right support: The National Service model, says, "People should be supported to have a good and meaningful everyday life - through access to activities and services such as education, employment, social and sports/leisure; and support to develop and maintain good relationships." This was not reflective of the lives people lived at Heatherside House. Activities were limited, generally restricted to within the service and did not support people to gain new skills or develop new interests.
●There was a disabling culture in the service which was embedded in staff practice. We were consistently given reasons why people couldn't do things, but very few examples of where there had been genuine engagement with people to enable them to achieve something new. People had been disengaged for a

sustained period and had become institutionalised. Staff now found it difficult to motivate people to try new experiences. Staff used refusals by people as a reason to discontinue encouragement and motivation. They did not review and reflect on the person's actions in order to better tailor the options they were offering.

●There was a maternal culture in the staff team. One staff member referred to themselves in the third person when talking to people, as though they were talking to a child. Another staff member supported people to prepare their breakfasts but told us they microwaved the milk as they didn't want people to burn themselves. No assessment had been completed to see if people were able to do this for themselves, there was just an assumption it wouldn't be safe. Whilst it is very important people feel safe and cared for where they live, no-one talked about or gave any real examples of people accessing education, employment, social and sports/leisure services, having a role in their local community or developing new and important relationships. We were given reasons why people would be unable to do this; for example they were not capable, or often refused support.

●Some decisions that affected the service were made without consulting people. People were not involved in choosing who worked at their service. There was no evidence people had been asked about what was important to them about staff members, or evidence they had been involved in the recruitment process. A resident's meeting recorded, "[Registered manager] informed everyone she was employing a new cook." People were not asked for their opinion or preferences.

● The layout of the home and the way it was used remained unchanged, apart from the addition of a small activity room. Name plaques had been put up to identify different parts of the building. There was no evidence to show people had been consulted about this or whether they knew why the plaques were there. People had not been involved in choosing these names and the home continued to operate as one group of residents with one staff team.

●The aims and culture of the service were not in line with current best practice. The home had an institutionalised feel and manner. Examples of this are given throughout this report. A lack of a person-centred culture at the home had not been understood or fully addressed by the staff team, registered manager or provider.

Current best practice was not understood and staff did not have the knowledge or skills to implement person-centred care which achieved good outcomes for people. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to effectively monitor the quality of the service or ensure it met with regulatory requirements. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had again failed to achieve compliance with the requirements of the regulations and remained in breach of regulation 17.

● The oversight and governance of the service was ineffective, and as detailed in the safe and effective sections of the report, the provider's director and the registered manager were particularly poor role models for the staff team. During the inspection they failed to follow current infection control guidance and the director was overheard speaking disrespectfully about a person who used the service. As a result of these observations the commission made a safeguarding alert and we requested an action plan detailing how improvements would be made. Following the inspection, the director said they did not recall speaking in this way. We completed a further visit to check infection, prevention and control and found the issues

brought to the attention of the provider had been addressed and found no further concerns.

● The registered manager was reliant on external agencies to guide improvement in the service. The service had received support from the local authority and a consultant commissioned by the provider since our last inspection. A professional commented that they felt Heatherside had been in a very difficult situation for a long time which meant in turn that the service was struggling to initiate or create anything new without direction and guidance from governing bodies and external agencies. The registered manager told us, "I am confident with the systems we have in place but QAIT (the local authority quality assurance team), haven't been able to come in. We need that basically, we need someone to come in and look at the improvements and the information and identify areas we still need to work on." A relative told us, "It feels like [registered manager] is waiting for some structure."

● The registered manager did not have the skills and knowledge to ensure the service improved, and had not reviewed or implemented best practice guidance to improve the service. When external organisations supporting the service to improve, such as the local authority, had suggested new ways of recording evidence or monitoring the service to improve performance, the advice had not been understood by the provider and registered manager, and sufficient action had not been taken to improve the service's performance. The number of checks to monitor the quality of the service had been increased. The registered manager told us, "The systems are 100% better. I feel they are supporting me." However, some audits had not identified gaps in records or practice and where gaps had been identified, action had not always been taken to address and resolve the issue.

●The registered manager and provider had not used up to date guidance and best practice to identify any risks to the service and the people living there. For example, Right support, right care, right culture highlights the need for providers to understand the inherent risk associated with closed cultures and put measures in place to ensure these cannot develop. There was no awareness in the service of the closed cultures guidance even through there were several indicators of closed cultures within the services. These included managers failing to respond to recommendations of others, poor application or understanding of the Mental Capacity Act (MCA), families not being aware of how their loved one is being cared for, the service being geographically isolated, the workforce comprising many members of staff who are either related or friends, and managers who do not lead by example. The failure to understand, recognise and take action to mitigate the risk of a closed culture left people in receipt of poor-quality care.

●Staff had not received the right development to recognise bad practice within the service. One staff member told us, "It's a really good care home and I'm wondering why we're not getting good on the reports." This showed a lack of understanding of what people could be achieving. The provider and registered manager provided one to one supervision to staff and held regular team meetings. However, staff did not understand best practice in learning disability services and did not always have the skills or knowledge to suggest appropriate improvements.

● The registered manager told us they felt well supported by the provider and the team. However, we received conflicting feedback about the service's leadership. Comments from relatives and staff included, "It seems well organised. The manager is brilliant", "I believe the service is well managed", "I'm cross with the provider. I feel sorry for [registered manager], it's put her under a lot of stress" and "It's not well-led. It's led by seniors (staff)."

The provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had failed to notify us of an injury sustained by a person living in the service as required by their registration.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to ensure people were engaged and involved in the service. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17

●People were still not engaged in the design of their service or support in a meaningful way. Information was not presented in accessible formats and when people were unable to respond to the information presented this was treated as consent or approval by staff and managers. The registered manager told us they sought feedback from people each day during their 'managers walkaround' but this was superficial information about whether people were ok and recorded small requests. It did not record meaningful conversations about changes people would like or suggestions of new experiences people might try. This meant the design of people's service and support essentially remained the same.
●There was no clear philosophy or approach around equality and diversity, and we found no tangible examples of how the service had recognised and responded to the needs of people from different backgrounds. No developmental work had been completed to identify any differences people had that they may want support with. Not all people living in the service were given the same opportunity to feedback as others. For those people unable to independently provide written or verbal feedback, the opportunities to share their views were limited. The provider's policy on equality, diversity and inclusion stated the service, "recognises that treating people unequally can result in people losing their dignity, respect, self-esteem and self-worth and ability to make choices." Our observations of people in the service suggested they were being negatively impacted, as described in the policy.
●There was no evidence of strong links with the local community beyond links with health and social care professionals. No action had been taken to identify community groups or organisations people might like to be involved with. The local authority day centre had changed to become a reablement service; however the provider and registered manager had not seen the benefit of this to people. The registered manager told us, "We are thinking of the option of opening a day centre here as the local one has closed." This would result in the increased isolation of the people living in the service.

The provider had not ensured all people's characteristics were considered to enable them to influence how the service was provided. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff and relatives told us the management team were approachable and they could approach them with any concerns they had.

Continuous learning and improving care
At our last inspection the provider had failed to ensure their oversight and governance arrangements were sufficient to effect the required change and improvements in the service. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

●The service has now been rated below Good since 2016. The provider and registered manager have failed to improve the service people received. Despite the ongoing external support being provided by the local health and social care authorities and by an external consultancy company, improvements had not been made. The provider and registered manager did not understand current best practice guidance and had failed to make improvements to the quality of support people received. Quality audits and spot checks were completed, but shortfalls in performance had not been identified or addressed.
●Records completed in the service by the staff and checks completed by the registered manager were not always completed accurately and did not lead to real change within the service. Feedback from some professionals suggested they had experienced similar concerns about improvements not being implemented. One professional told us they had recently again raised concerns about MCA assessments. Another professional told us there had been risk management issues that raised concerns over a person's health needs which took some time to resolve. This did not reflect a culture of continuous improvement.

The provider's governance systems were still ineffective in improving the service people received. This was part of a continued breach of continued Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
●We received positive feedback from professionals about their relationships with the registered manager and staff. They told us they were approachable and contacted them for advice when necessary.

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 registered manager was open and honest during the inspection.
● A professional confirmed that the registered manager was honest about any difficulties they faced.
● People's relatives reported that they thought the registered manager and staff were open and honest.

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 had not notified us of a serious injury to a person living in the service.

The enforcement action we took:

continue with action to close the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not being delivered in line with evidence-based guidance. The provider had not ensured staff promoted choice, inclusion, control and independence at all times.

The enforcement action we took:

continue with action to close the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were still not always treated with dignity and respect and their independence was not supported.

The enforcement action we took:

continue with action to close the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured the registered manager and staff understood the principles of the MCA or how to uphold people's rights.

The enforcement action we took:

continue with action to close the service

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 and mitigate all risks and this exposed people to the risk of harm.

The enforcement action we took:

continue with action to cancel service

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 protect people from abuse and improper treatment.

The enforcement action we took:

continue with action to close service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements.

The enforcement action we took:

continue with action to close the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The providers failure to appropriately assess the services staffing needs and ensure identified staffing levels were achieved exposed people both to risk of harm and limited their choices and freedoms. The provider had not ensured staff had the opportunity to develop their skills and knowledge regarding the specific needs of the people using the service to enable them to deliver support based on best practice.

The enforcement action we took:

continue with action to cancel service