Autumn House Care Limited

Autumn House Residential Home

Inspection report

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Sandown
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Date of inspection visit:
11 January 2021
22 January 2021
16 February 2021

Date of publication:
30 March 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Autumn House Residential Home is a care home providing personal care to people aged 65 and over and predominately supports people were living with dementia. The care home is registered to accommodate up to 42 people. There were 36 people using the service at the time of the inspection.

People's experience of using this service and what we found
The provider and registered manager had not complied with a requirement of their registration and had not recognised where they had responsibility to meet people's assessed needs. Quality assurance systems had not picked up the concerns we identified in relation to infection control, training, care planning and risk assessments.

Concerns regarding infection prevention and control procedures were found. Practice was not in line with government guidance for care homes during the pandemic and placed people at risk of harm.

Risks associated with people specific needs were not always assessed and plans implemented to mitigate these risks. Care plans and risk assessments did not provide a clear plan as to what people's needs were or how these should be met. This meant people were at risk of being provided with inappropriate care which could result in harm.

Systems and processes to safeguard people from the risk of abuse were not robust and safeguarding concerns were not always dealt with appropriately by the management team when issues or concerns were raised with them.

Recruitment practices were effective and there were enough staff available to meet people's needs.

There were effective systems in place in relation to medicine management and people received their medicine as prescribed.

Staff spoken with enjoyed working at Autumn House and felt well supported by the registered manager. People and their family members gave us positive feedback about the home and told us that staff were very kind and caring. Family members spoken with, also confirmed they had regular communication with the management team and staff, and they felt able to discuss any concerns or issues they had with them.

The environment was warm and homely. We observed positive communication between staff and people.

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

Rating at last inspection
The last rating for this service was Good (published September 2019).

Why we inspected
The inspection was prompted due to concerns we had received about infection control practices, staffing levels, staff skills and the monitoring and management of people's medical needs. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Autumn House Residential Home on our website at www.cqc.org.uk.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection and we have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.
Enforcement

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

We have identified breaches in relation to the management of risks associated with people's needs, infection prevention control, governance systems and the failure to notify CQC about significant events without delay.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Autumn House Residential Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by two inspectors over a period of 37 days. This was due to the impact the COVID-19 outbreak was having on the service. Inspectors visited Autumn House Residential Home on 11 and 22 January 2021 and 16 February 2021.

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

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

Notice of inspection
Inspection visits on the 11 and 22 January 2021 were unannounced. The service was given one-hour notice of the inspection visit on the 16 February 2021.

What we did before the inspection
Before the inspection we requested the registered manager provide records and documentation for us to review in relation to infection, prevention and control processes. We reviewed the information, we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We sought feedback from the local authority and professionals who work with the service.

We used all of this information to plan our 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.

During the inspection
We spoke with three members of the staff team, including the provider, registered manager and duty manager. We also spoke with two people who lived at the service. We reviewed the safety of the environment, reviewed medicine processes, looked at staff files in relation to recruitment and a variety of records relating to the management of the service.

After the inspection
We reviewed a number of records electronically provided by the service, including multiple care plans and risk assessments and a variety of records relating to the management of the service, such as, quality assurance records, training information, records of accidents and incidents and additional supporting information provided. We continued to seek clarification from the provider and registered manager to validate evidence found.

We contacted and spoke with 10 family members of people who used the service and nine members of staff. We also received feedback for two healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

● Staff did not always follow good infection prevention and control practice. For example, on the first day of our visit during an outbreak of COVID-19 in the service, we saw clinical waste bags lying on floors, which were open with used personal protective equipment [PPE] inside them. One open clinical waste bag was lying across a clean box of PPE, which meant there was a high risk of cross contamination between clean and infected PPE. In addition, we saw clean staff uniforms lying next to an open laundry basket where dirty uniforms were placed. This was a cross contamination risk as staff were supporting people who had COVID-19. We acknowledged that due to the COVID-19 outbreak in the service during our visits, staffing levels were reduced due to staff testing positive for COVID-19, however the provider had failed to ensure safe infection, prevention and control (IPC) processes were being followed. We raised this concern with the provider who took immediate action to address the management of clinical waste and the storage of used staff uniforms.

● Individual risks to people from social isolation had not been assessed or identified in their care plans. The registered manger told us they had not assessed the possibility for indoor visits from people's relatives following the government's winter visiting guidance published in September 2020, such as using screens. We discussed this with the registered manager who told us they had made the decision to stop all non-essential visits inside the home, as it was their decision to make to keep people safe. The government guidance states that 'providers should develop a policy for limited visits (if appropriate), in line with up-to-date guidance from their relevant Director of Public Health and based on dynamic risk assessments which consider the vulnerability of residents.' This meant people had not had risks in relation to their human rights and their physical and mental health assessed or safely managed. The registered manager and provider had failed to follow government guidance and to recognise and take appropriate action, to mitigate both the short and long-term impact on people's wellbeing and mental health.

● We were not assured that the provider was preventing people and staff from catching and spreading infections. Staff did not always wear Personal Protective Equipment (PPE) in line with national guidance. For example, the service had recently had a Christmas party and the registered manager, provider and staff did not wear masks during this event. We saw evidence of this posted on a social media sight, where staff, the registered manager and the provider all had close contact with people. In addition, the registered manager described a short period of time where they had allowed some people's relatives to visit inside the home and hold their relative's hands. Although PPE was being worn during these visits and health monitoring questions had been asked, no risk assessments were completed, and no screens or additional measures put in place in line with government guidance. These examples demonstrate that people were placed at risk of infection from COVID-19 and we were not assured that the provider or registered manager understood their responsibilities when assessing risks and taking action for visiting arrangements.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people and to safely manage infection control risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Cleaning processes were in place to mitigate infection control risks and audits were completed to evidence increased levels of cleaning and infection control practice. The provider had policies which related to infection, prevention and control [IPC], PPE and outbreak of infections management. However, these policies were not always consistently followed by staff, as described above.
● The service appeared to be clean and the registered manager told us cleaning products used in the home had been reviewed and complied with the standard needed to sanitise COVID.
● People were supported to have contact with their family's via phone calls and video calls. In addition, during the summer of 2020, garden and window visits were facilitated prior to the outbreak. End of life visits were offered to family if needed, but the registered manager told us relatives had chosen to have contact via video calls, rather than enter service.
● We were assured that the provider was admitting people safely to the service. The registered manager confirmed any admissions since start of pandemic had a negative test before arriving at the home and then isolated in their rooms for 14 days. This admission process was in line with the latest government guidance.
● Staff had received on-line training in infection control and the use of PPE, including how to safely put on and take off PPE.
● We were assured that the provider was accessing testing for people using the service and staff.
Staff were having regular Polymerase Chain Reaction (PCR) tests and also using lateral flow tests (LFT). Staff and people testing positive were isolated as required.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to the health and safety of people were not being managed safely.
● Risk assessments in place were not specific to people's individual needs and did not provide staff with clear and detailed information on how to manage or mitigate specific risks to people. For example, there were no specific or detailed care plans or risk assessments in place for; people who were at risk of choking, people who had specialist care needs in relation to continence management or for specific health needs people had, such as diabetes. Therefore, this meant that staff were not provided with detailed guidance about how these needs should be managed, risks mitigated and actions for them to take if a concern arose.
● People's care plans and risk assessments did not provide a clear plan as to what people's needs were or how these should be met. Care plans and risk assessments viewed often contained conflicting information. For example, in one area of a person's risk assessment/care plan it said the person was to be weighed weekly but then in another part of this care plan/risk assessment it stated, they were to be weighed monthly. This meant people were at risk of not being provided with their assessed care needs due to the conflicting information within their care records.
● Care plans/risk assessments lacked detail about what equipment people required to enable them to mobilise safety. Some of the care plans viewed stated; 'Ensure correct aids are used' but did not always give detail on what these aids are. This meant people could be at risk of falls and injury through the use of inappropriate moving and positioning equipment.
● Where people were at risk of malnutrition, dehydration and weight loss this had not always been effectively monitored to allow timely action to be taken were required. For example, on one person's weight record it showed that in a seven-month period they had lost two and a half stone. There was no evidence that this person's weight was rechecked, that the service contacted healthcare professionals to discuss this or that increased monitoring was put in place. Additionally, their care plan and risk assessment did not reflect this concern. This was brought to the attention of the provider who immediately investigated this.
● Monitoring of accidents and incidents was not robust. Although these were recorded and logged on

accident forms, there was no clear evidence that investigations had taken place in a timely way or that these were monitored to identify patterns and trends. We were provided with a number of accident reports which had been completed following incidents. These did not include an analysis of why these incidents may have occurred or that measures had been implemented to reduce the likelihood of this happening again. Further information in relation to these were provided by the registered manager, this information was not dated as to when the actions were taken. For example, we received three accident forms in relation to falls for one person, however, we only received one detailed additional information of what actions were taken and this was not dated. Therefore, we could not be assured that all incidents and accidents were analysed, and actions taken in a timely way.

The failure to safely manage risk to people using the service and to take action to mitigate risks to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although we identified care plans and risk assessments lacked detail in relation to people's specific health and care needs, the registered manager was able to provide us with records which demonstrated people's food and fluid intake, elimination, repositioning and health following potential head injuries had been monitored.
● We discussed lessons that had been learned during the COVID-19 pandemic with the registered manager and provider and they told us that this had resulted in changes to staff allocation, which has included splitting the staff team to allocated areas and residents. They explained that they had seen the benefits of this for people, including them building greater relationships with staff.
● The registered manager also explained that following recent concerns that had been raised the number of 'wakeful' night staff had been increased from two staff to four.
● People had up to date Personal Emergency Evacuation Plans (PEEPs) in place, these described the support people would require in the event of a fire or similar emergency. Checks of fire equipment such as alarms, door, lighting and fire extinguishers were completed regularly.
● Environmental risk assessments, general audit checks and health and safety audits were completed. Action had been taken where highlighted, to help ensure the safety of the environment.
● Gas and electrical safety certificates were up to date and the service took appropriate action to reduce potential risks relating to Legionella disease.
● There were plans in place to deal with foreseeable emergencies.

Staffing, recruitment and training
● The provider's training records were not up to date and were disorganised. At the time if the inspection we were not able to be assured that staff had received adequate training in a timely way to equip them to do their roles, safely and effectively. For example, the providers training records showed, one staff member had worked at the service for approximately eleven months at the time of the inspection the training matrix showed that they had not received any training since being at the service except infection control training. These training records also showed a second staff member who had worked at the service for approximately eighteen months had not received essential training including, safeguarding, medication and health and safety. Following the inspection, we received additional information which demonstrated staff had received training updates.

We recommend the provider and registered manager ensure robust processes are in place to allow effective monitoring of training and to ensure training in updated in a timely way.

● We received mixed views from family members and healthcare professionals about competence, skills and knowledge of the staff. For example, a family member told us that, "Staff are friendly and know what to do."

Another said, "The staff are all really good and are always smiling." However, a third family member said they felt the management in the home were a, "law unto themselves" and "making it up as they go along." Health professionals had also raised concerns to the local authority about the knowledge and skills of the staff.

● There were enough staff available to keep people safe and to meet their needs. All the people and relatives we spoke with told us they felt there were sufficient staff. Throughout the inspection, we observed that call bells were responded to quickly.

● Staffing levels were determined by the number of people using the service and the level of care they required. The management team regularly monitored the staffing levels by observing care and speaking with people and staff to ensure that staffing levels remained sufficient.

● The registered manager told us staffing levels were constantly reviewed and changes to staffing levels would be made where required.

● People were supported by consistent staff. Short term staff absences were covered by existing staff members, this helped ensure people received continuity of care.

● There were clear recruitment procedures in place. These included reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. One person said, "I don't have any worries at all, the staff are lovely."

● Family members told us they felt their loved ones were safe living at Autumn House. A family member said, they had, "Never had a moment worry." Another told us their loved one was, "safe, happy, well fed and warm – what more can you ask for."

● Staff told us they received safeguarding training; however, we could not be assured this had been received in a timely way. Additionally, not all staff spoken with were able to describe who they would report concerns to if these were in relation to the management of the service or if the management team failed to act on concerns. However, other staff were able to clearly describe how and who concerns should be reported to including the safeguarding team and CQC.

● The management team did not always respond in a timely manner, in line with local safeguarding procedures when safeguarding concerns were reported to them. For example, a serious concern had recently been reported to the registered manager, however they did not act appropriately when this concern was raised with them by contacting other relevant authorities.

● There was a culture of investigating concerns within the service before referring onto the local authority safeguarding team. We discussed safeguarding processes with the registered manager who described the actions they would take if a safeguarding concern was raised with them. The registered managers response did not include any reporting to the local authority, CQC or police but described an internal investigation process. This meant we could not be assured that people were safeguarded from abuse by an open and transparent service.

We recommend the provider and registered manager review local safeguarding adults board procedures to ensure robust processes are in place to safeguard people from abuse.

Using medicines safely

● People were supported to take their medicines safely.

● Medicine administration care plans provided information for staff on how people liked to take their medicines and important information about the risks or side effects associated with their medicines.

● People were provided with 'as required' (PRN) medicines when needed. PRN plans included information for staff to understand when these medicines should be given, the expected outcome and the action to take if desired outcome was not achieved.

● There were systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely.
● Full stock checks of medicines were completed monthly to help ensure medicines were always available to people.
● Medicines that have legal controls, 'Controlled drugs' were appropriately managed and there were safe systems were in place for people who had been prescribed topical creams.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider and registered manager had not complied with a requirement of their registration, to notify CQC about significant events without delay. Although the provider and registered manager had notified CQC of some events as required, not all notifiable events had been reported.
- On review of the accident and incident records provided by the service we identified that the registered manager or provider had failed to notify us of four counts of possible serious injury to people that had occurred between the months of July to October 2020. Additionally, the service had failed to notify us of all safeguarding concerns that had been raised in relation to the service over the last six weeks. This limited our ability to perform our regulatory duty of monitoring events that occurred at the service.

The failure to notify CQC of significant events without delay was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- The registered manager and provider failed to recognise where they had responsibility to meet people's assessed needs within the service. The registered manager did not understand their responsibility to ensure certain health needs and intervention were assessed and plans implemented for their staff to follow to ensure people received the right support at all times. The registered manager told us they felt this was the responsibility of external health care professionals, who was only accessing the service twice a week and with prior appointment. This meant we could not be assured that people's health care needs were being monitored and met safely.
- The registered manager and provider failed to follow and adhere to the latest government guidance in relation to COVID-19. This placed people at risk.
- Records were not always able to demonstrate that the service was safe. For example, systems to ensure and demonstrate that all staff had completed all necessary training were not effective and the provider and registered manager failed to evidence or identify staff had received required training in a timely way.
- The provider's quality assurance system comprised of a range of audits; however, the audits had not picked up the concerns we identified in relation to infection control issues, training and care planning and risk assessments. You can find more information about this in the Safe section of this report.
- Throughout the inspection we raised concerns with the registered manager and provider where we found risks were not managed safely. However, we were not assured that action would be taken where required as

the registered manager and provider did not acknowledge all the concerns we raised. This meant we could not be assured that action would be taken to address all the issues and concerns highlighted during the inspection.

The failure to operate effective systems to assess, monitor and ensure the quality of the service was a breach of regulation 17 of the health and Social care Act 2008 (regulated Activities) Regulations 2014.

● There was a clear management structure in place, which consisted of the provider, a training coordinator, the registered manager and a duty manager. Each had set roles and responsibilities.
● The registered manager felt well supported by the provider who was actively involved in the running of the home.
● Staff communicated well between themselves, for example during handover meetings, to help ensure people's needs were met.
● The registered manager completed observational spot checks to assess care being delivered by staff. Additionally, the registered manager completed daily checks of all areas of the home to monitor the environment and people's general wellbeing.
● Policies and procedures were in place to aid the running of the service. For example, there were policies in relation to safeguarding, medicine, training and infection control. These were easily accessible to staff. However, we were not assured that these were being robustly implemented and following by staff due to the concerns we found.
● The registered manager was aware of their responsibilities under the duty of candour and provided a written example of when this had been followed.
● The provider had displayed the home's previous rating in the entrance lobby and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Health and social care professionals told us the culture of the service was not always open and transparent and the registered manager and provider were not consistently cooperative or collaborative with external professionals. For example, one professional told us, "The relationship between us and Autumn House is variable, as differences in professional opinion can often happen." Another professional told us, "This is a really difficult service to work with."
● At the time of the inspection we also received feedback from health and social care professionals stating the service had been resistive to visits from professionals. In addition, the providers were resistant to CQC inspectors entering the service for the purposes of completing our inspection. Although there was an outbreak of COVID-19 at the service, and visiting restrictions were in place in line with government guidelines, external professionals should not be restricted from visiting or gathering information in order to meet people's health needs or monitor the service, which is a requirement under the Health and Social Care Act (2008).
● During our visits we saw people were being cared for in their bedrooms. At the time of our visits this was necessary and followed guidance from the Department of Health and Social Care due to the outbreak of COVID-19 at the service. However, the registered manager and provider told us that they would continue to predominantly support people in their rooms following the outbreak of COVID-19 for the majority of time. The provider told us they felt people would be calmer and less impacted by other people's behaviours if they were supported in their rooms with a small core team of staff that knew them well. We discussed the potential risks to people's wellbeing and the risks of social isolation by continuing to support people predominantly in their rooms. However, the provider and registered manager failed to provide us with any evidence or assurances that people's human rights had been considered or that they would be supported in line with their individual needs and wishes.

The provider failed to ensure good governance to prevent a closed culture developing. This was a breach of regulation 17 of the health and Social care Act 2008 (regulated Activities) Regulations 2014.

● People and their relatives spoke positively about the management of the service and the staff and told us they would recommend the home to others. Comments included, "I feel that [name of registered manager] really cares about the residents", "All the staff are very good – really seem to care" and "They [staff] are always smiling and happy." During the inspection we observed some interaction between staff and people. Staff listened to people and spoke with them respectfully.
● People also told us the staff were kind, helpful and respected their wishes. One person said, "I'm very happy here, the staff are fun and if I don't feel well, I can stay in bed." Another person told us, "I can't fault them [staff] its totally lovely."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff spoken with enjoyed working at Autumn House and felt well supported by the registered manager. A staff member said, "The manager couldn't do anymore she's so on the ball." Another staff member told us, "The management team are really supportive to me, they are always there if you need them." A third staff member said, the registered manager was, "brilliant, very approachable." The registered manager told us, "We are sending out positive emails to staff, we want to keep staff morale up. We value every single member of staff."
● The provider created opportunities for people and relatives to provide feedback. Prior to the COVID-19 pandemic quality assurance questionnaires were sent to people and their families annually. Due to the COVID-19 pandemic the provider told us they had not been in a position to complete the latest quality assurance questionnaire. Therefore, feedback had been gathered during frequent telephone discussions and email correspondence with people's families and during the registered managers daily contact with the people living in the home. Family members spoken with, confirmed they had regular communication with the management team and staff, and they felt able to discuss any concerns or issues they had with them.
● Resident and staff meetings were held, and the management team had an 'open door' approach, meaning staff could raise any issues or questions at any time.
● Throughout the inspection it was evident people felt able to approach the staff and discuss any issues they had.
● The registered manager also shared with us a number of recent 'Thank you' cards that had been received from family members. These described how staff had treated people with care and compassion.

Continuous learning and improving care
● The provider's quality assurance processes to enable them to monitor the service provided, were not always robust or effective. We could not identify a clear process in place that demonstrated the provider and registered manager actively reviewed their systems and processes. This meant we could not be assured any actions needed would be identified or carried out promptly.
● We were not assured accident and incident records contained sufficient detail or action was taken when required. The registered manager told where incidents or accidents had occurred, these were shared with staff during handovers, staff meetings and supervision. However, we found there was no detailed process in place which demonstrated learning from these incidents.
● We reviewed two complaints received by the service from family members. Although the registered manager had responded to these complaints in writing, there was no evidence which demonstrated that they had reflected on the concerns raised to determine if any changes to practice was required to improve the quality of care provided to people.

Working in partnership with others

● We received mixed views in relation to the service working in collaboration with all relevant agencies in order to provide essential information, to enable them to monitor or review people's care needs. Some feedback we received from health and social care professionals described how on occasions, requests for information were not provided in a timely way or was unclear and required further contact with the registered manager or provider. One healthcare professional told us, they were always contacted appropriately by the service and staff always followed any suggested treatment plans. However, another healthcare professional said, that they were not always contacted appropriately, treatment plans were not always adhered to, fluid and turning charts to not be continually filled in as required.

● The registered manager understood how to contact advocacy services to support people who did not have relatives to act for them. An advocate is an independent person whose role is to befriend people and help them express their views.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of significant events without delay was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 robustly assess the risks relating to the health safety and welfare of people, to safely manage risk to people and to take action to mitigate these risks and to safely manage infection control risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and ensure the quality of the service. This was a breach of regulation 17 of the health and Social care Act 2008 (regulated Activities) Regulations 2014.