

Autism Anglia

Lambert House

Inspection report

36 Notridge Road
Bowthorpe
Norwich
Norfolk
NR5 9BE

Tel: 01603749845

Website: www.autism-anglia.org.uk

Date of inspection visit:

29 September 2022

03 October 2022

11 October 2022

Date of publication:

17 November 2022

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Inadequate 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Lambert House is a residential care home providing personal care to up to 11 people. The service provides support to autistic people. At the time of our inspection there were 11 people using the service. The care home is a large two-storey building, with a communal bathroom and toilet on each floor. A communal lounge, dining room, recreation room and sensory room were located on the ground floor.

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

People's experience of using this service and what we found

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

Right Support: Model of Care and setting that maximises people's choice, control and independence
The model of care did not maximise people's choice, control and independence. People were subject to restrictive practices without proper due regard to legal processes and requirements. 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. People were not supported to engage in activities that met all their needs. Some people living in the service had sensory loss but were not supported to engage in activities that met these needs. People were not always supported to communicate their wishes and feelings as there was limited use of communicate strategies.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights
People were not supported in a manner which promoted their dignity, privacy and human rights. Some practices dehumanised people living in the service which was of significant concern. People were living in a poorly maintained and dirty environment which did not uphold their dignity. Safeguarding concerns had not always been shared in a timely manner. The support provided was not person-centred because staff did not follow risk assessments or care plans. This placed people at risk of harm. People were not supported by staff who knew them well due to the high use of agency staff and ineffective systems ensuring staff understood how to support people.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

We identified a closed culture in the service. A closed culture is 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. The provider had not taken effective action to identify and address the poor culture in the service. Leadership was weak and did not hold staff to high standards. Governance systems in the service were ineffective as they had failed to ensure regulatory requirements were met.

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 15 May 2019).

Why we inspected

The inspection was prompted in part due to concerns received about staff conduct in relation to people using the service, restrictive practices and governance. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations

We have identified breaches in relation to safeguarding people from risk of harm, safe care and treatment, person-centred care, safe use of medicines, premises and equipment and good governance.

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

Follow up

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not 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.

Inadequate ●

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Lambert House

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

The inspection was carried out by 3 inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type

Lambert House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Lambert House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

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

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection

None of the people who used the service could speak with us verbally. We observed the care and support provided. We spoke with eight relatives about their experience of the care provided. We spoke with 12 members of staff including the registered manager, three interim managers, three agency staff members, three core staff members, the chief executive officer, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the registered provider.

We reviewed a range of records. These included various care and support records for five people using the service. We reviewed all personal evacuation plans and deprivation of liberty applications. We looked at three staff files in relation to recruitment and three agency staff profiles. A variety of records relating to the management of the service, including audits and incidents were reviewed.

Due to the significant concerns identified during the inspection we met regularly with the provider, and professionals from the local authority and integrated care board to discuss and monitor the concerns identified.

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding concerns had not been shared in an appropriate and timely manner. This had impacted on the ability of the local authority to carry out their duties.
- Restrictions on people's movement and access to water had been implemented without proper and legal authority to do so.
- We identified staff practices which were degrading to people living in the service and raised significant concern.

Systems and processes were not operated effectively to prevent and investigate allegations of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- Risks to people's safety were not managed effectively and this put people at risk of harm.
- Some people living in the service were at risk of eating or drinking harmful substances. This risk was not managed. On one occasion we found a cleaning product, containing bleach, unsecured in a communal activity room without staff present. The ingestion of cleaning products was a known risk for some people living in the service. For another person we found their bedroom contained known items which the person was at risk of ingesting and could cause significant harm.
- Risks to people were not monitored. One person had been identified as being of low weight however their weight records showed their weight was not regularly monitored. Their weight had been checked in February 2022 but not checked again till June 2022. At this point it was identified the person had lost 10lbs, despite this no further checks of the person's weight had been taken by staff at the time of our inspection.
- Two people living in the service had been assessed as being at risk of drinking excessively to such an extent that they could become unwell. Risk assessments specified their fluid intake should be monitored, however this was not taking place.
- No bowel monitoring or associated care plans were in place this was despite known risks being identified regarding people's bowel management.

Actions to mitigate risks of harm to people were not effective. Not all risks to people had been assessed and considered. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

- We identified serious concerns in relation to the cleanliness of the environment. Faeces was found around the communal toilet on the first floor on two of our visits. This included on the inside of the door handle and the flushing button. We observed people using this toilet with faeces present on both visits.
- The water in toilets and accessible sinks had been switched off. Staff told us this was to manage the risk of people drinking excessively, however no consideration had been given to how this impacted good hand hygiene. No other measures, such as hand sanitiser, had been implemented.
- The environment was not clean and, in some areas, posed significant infection control concerns. For example, we found the back of a chair next to a person's bed had white mould growing on it.
- Bedding and towels in people's rooms were soiled.
- Soft furnishing and seating were in poor condition with furniture padding exposed. This posed a risk as it was not protected and could not be easily cleaned.

Effective actions had not been taken to prevent and control the risk of infection. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Visiting in care homes

- There were no restrictions on people visiting the home. People's relatives told us they did not visit frequently however as people were supported to visit their relatives at home.

Using medicines safely

- Medicines were not managed safely. We found improvements were required with basic medicine management. For example, staff did not sign to say they had applied topical creams. Liquid medicines, eye drops and creams did not have a date of when they were first opened. Therefore the service could not be assured that these medicines were safe to use.
- Medicines were stored securely. People's medicines were stored in individual boxes with their names on it. However, we found one box had different names written on either end. This raised the risk that medicines might be administered incorrectly.
- People's medicine administration records (MAR) did not reflect some of the medicines people had in place. For example, we saw the dose of one person's medicine had been increased. Both the previous dose and the current dose had been printed on the MAR chart. This increased the risk of incorrect medicines being administered. Staff had not previously raised this issue with the GP or the pharmacy so this could be corrected until our inspection.
- Some medicines were listed on people's medicine administration charts but had not been administered for some time. No reviews of whether these medicines were still required had taken place.
- Medicine audits had not been effective at identifying issues with medicines. For example, one person's medicine records stated they had prescribed several "as required" medicines for constipation. Their medicine records showed there were being given several times a day. The registered manager told us these medicines had been changed to daily however the person's records had not been updated to indicate this.
- Person centred information was available so staff knew how people liked to take their medicines. However, staff administering medicines did not always understand what the medicines were for.
- When medicines were prescribed as and when required (PRN), protocols were generic and did not provide person centred details to support staff when it was appropriate to administer. Some people had PRN protocols for medicines which they were no longer prescribed. The service did not regularly review PRN protocols so they did not reflect people's needs correctly.
- Care plans were difficult to understand and lacked key information about people's medicines. For example, there was no information about how to manage a person with epilepsy if they had a seizure.

Medicines were not managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

- There was a high use of agency staff in the service. Rotas showed on some shifts at least half the staff were agency staff.
- Following our first inspection visit we were informed by the CEO and Nominated individual that all the senior staff, including the management team, were no longer working in the service. This had placed increased pressure on the service and as a result, even higher use of agency staff. The provider put in place interim managers from their other services on a rota basis.
- Whilst there remained enough staff on shift during our inspection the provider informed us that they couldn't guarantee this due to their reliance on staffing agencies.
- Due to the concerns raised regarding staffing levels and lack of management in the service, we worked closely with the local authority and provider to monitor this situation and risks to people's safety.

Learning lessons when things go wrong

- Incidents were reviewed at provider level however this was not always dynamic and responsive enough. For example, a number of incidents involving one person had happened over the course of a few days. However, no feedback to the interim management team on triggers or learning had been provided. The management team themselves had not reviewed this to identify any patterns or concerns.

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- The environment was in a poor state and required refurbishment. We identified significant concerns such as a broken window downstairs which meant the window could not be closed. We noted this contributed to the communal areas feeling cold. We saw broken radiator cover with rough edges and noted it had leaflets and other debris inside it. A downstairs communal toilet had water covering the floor around it. Communal bathrooms were in a poor condition and required refurbishment.
- People's rooms were poorly maintained with notable damaged walls and stained and loose ceiling tiles.
- We identified significant concerns with the cleanliness of people's environment. Fans in communal bathrooms and toilets were caked in dust and dirt. Jugs on baths in communal bathrooms were dirty as were bathmats. We noted significant accumulation of dust on and around people's items in their bedrooms.
- Whilst there were communal spaces such as a large recreation room and sensory room, these were not well utilised. On each of our three visits we found the sensory room was locked and therefore not accessible to people.

The premises was not properly maintained and was not clean. This was a breach of Regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We raised these concerns during the inspection as a result the provider commissioned a deep clean of the service and put in place a schedule of maintenance work. This included taking urgent action to address the more significant areas of concern.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We identified restrictions in place such as limiting people's access to their personal electronic devices, their bedrooms and water, which had not followed the correct processes as required under the MCA. This meant we could not be sure these decisions had been made in the least restrictive and best interests of the person.
- Whilst DoLS applications had been made, staff were unable to demonstrate that the restrictions identified had been considered as part of DoLS applications.

Due regard had not been given to ensuring the care and support provided was in accordance with the MCA. This was a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We raised these concerns with the provider during the inspection. The provider took action to review these restrictions and assess if they were necessary. They took action to make amendments to some restrictions in some cases.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not always fully assessed and did not always have supporting care plans.
- We identified some instances where language used to refer to people using the service was out of date and did not reflect best practice.
- Staff were unaware of guidance and best practice in relation to supporting people in some areas such as bowel management.
- Nationally recognised assessment and support tools were used to support people with distressed or communicative behaviour. However, we received some concerns during the inspection from social care professionals on how effectively staff implemented this approach.

Staff support: induction, training, skills and experience

- We identified serious concerns with staff practice and the support provided to people using the service. This meant, whilst staff had received training in a range of areas, we could not be confident staff were supported effectively to carry out their role.
- We spoke with some agency staff who had not been supported to have sufficient knowledge of people and the systems in the service to provide effective support.

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

- Systems to ensure people ate and drank enough, such as food and fluid charts, were not in place as required and specified in people's risk assessments. This meant we could not be confident people were eating and drinking the right amounts.
- We observed the mealtime experience and noted this was not a pleasant experience for people. An assigned seating plan for people was displayed in the dining room. This raised concerns about an institutional approach to the support provided. We noted there was little interaction between people and staff, and the room was notably silent.
- The kitchen staff had worked in the service for many years and knew people well. They told us how they planned the menu to take account of people's likes and dislikes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

- Staff did not ensure good oral hygiene. We observed toothbrushes in people's rooms which were in poor condition.
- Oral health charts were pinned up in the bathroom for staff to record what areas of teeth people had been supported to clean. However, we noted these had significant gaps. We observed one person grinding their teeth loudly however this was not covered in the person's care plan or risk assessment. We did not find any consideration of what dental input and advice the person had received had in relation to this.
- Whilst people had hospital passports in place these had not been kept up to date so it was not clear the correct information would be provided in the event of a hospital admission.
- Staff supported people to access health care appointments and records confirmed this.

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- Observations of staff support raised concerns of dehumanising practices within the service. For example, we observed a member of staff sitting in the doorway facing into a person's bedroom so that the door was unable to close. We observed the person lying on an uncovered mattress. The person was naked from the waist down and was completely exposed to anyone walking past their room.
- During our inspection visits we identified multiple occasions where staff did not act to ensure people's dignity. At two separate visits we found people using the toilet were not supported by staff to protect their dignity. On one of these occasions one person was left using the toilet for an hour with no staff intervention.
- Whilst we noted some individual staff interaction with people was kind and caring, we did not find this to be consistent throughout the inspection. Most of the people using the service were supported on a one-to-one basis by staff. We observed there was limited engagement from staff with the people they were supporting. On one visit we noted an agency member of staff providing support to one person whilst wearing ear pods and using their mobile phone on several occasions.
- The cleanliness and poor condition of people's items, as well as the physical environment, did not show that staff treated people with respect and promoted their dignity. On one visit we found duvets placed in large garden plant pots. We raised this with the provider who told us in response they would put in place an outside designated drying area.

People were not treated with dignity and respect. Their privacy was not maintained. This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to express their views and be involved in making decisions about their care

- People living in the service relied on nonverbal means of communication. However, during our observations of the support we did not see use of communication tools in place. For one person we noted their care plan referenced the use of a communication book. We asked the registered manager to see this and they told us the person didn't have one.
- During interaction with one person using the service staff providing them with support did not support the person to engage with us. As a result, the person was not supported to effectively communicate.
- We requested evidence on key worker sessions for people living in the service however this was not provided. This meant we could not be confident systems to support people to express their views were in place.

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People living in the service required additional support with communication. However, we did not see staff supporting these needs during any of our visits. During our visit we engaged with people living in the service however staff supporting them did not proactively support this engagement. On one occasion we had to ask a staff member supporting a person to explain to us what their signs meant and what signs we could use in response.
- We were not confident people were receiving person centred care. The support we observed was not person-centred but basic and institutionalised. Some of the agency staff spoken with did not have a good knowledge of the needs of the people they were supporting and how to support them.
- The provider told us they recognised this as a valid concern as a result of the exceptional staffing challenges the provider was facing.
- People's care plans had not always been reviewed and updated where their needs had changed. It was not always clear why people's care plans were not being followed. For example, one person had a care plan in place detailing the use of sensory items. However, the registered manager told us these items were not in use. There was no review or evidence in the care plan to show why this was the case.

People did not receive person-centred support that met their needs, this included in relation to their communication needs. This was a 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

- People had weekly activity plans in place, however it was not clear how activities had been planned in relation to people's needs and interests. For example, one person's activity plan consisted of going for walks in local areas. The person had sensory loss but no sensory activities were shown as planned.
- A number of people were living with sensory loss. We visited the service on three different occasions at different times and found at each visit the in-house sensory room was locked throughout the duration of our

visits. On one of these occasions we noted one person's activity planner said they should be using this.

- People were supported to spend time at with their families, this included planned overnight stays.

Improving care quality in response to complaints or concerns

- Complaints had been recorded and appropriate actions taken in response.
- Information on how to complain or raise concerns was available in the service, this included in easy read format.

End of life care and support

- Nobody living at the service required support with end of life care.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Quality monitoring processes had been ineffective. There were significant short-falls within the service which had not been identified. For example, infection control audits had been carried out and no concerns noted at the same time we found substantial concerns.
- There were serious concerns with the culture and practice in the service which the provider had failed to identify and address. This placed people at risk of harm.
- The local authority had carried out their own assessment of the service, shared with the provider, in April 2022 which contained some concerns with staff practice. It had noted that a member of staff was seen sitting outside a person's room looking at social media on their phone. At our inspection we noted similar concerns with staff not engaging with the people they supported and a staff member using their mobile phone whilst providing 1-1 support. This meant we could not be confident effective action had been taken to address staff culture at the service.
- During the inspection we noted one person's hair had been closely shaved, the person's appearance had been significantly altered. We asked the interim management team why this had been done and why. They told us they did not know. We asked them to investigate further and provide us with an explanation. We did not receive one. This raised serious concerns about the oversight and supervision of staff conduct.
- The provider was made aware of the significant and serious risks at the service immediately after our initial visit. They took immediate action to address risks identified, however we found the actions taken ineffective. This was because we carried out several visits to monitor risks and improvements and found significant risks remained at each visit.
- People's records had not been updated when their support had changed which meant the information held was inaccurate. Ensuring records are complete, accurate and contemporaneous is a regulatory requirement.

Governance systems were not effective in ensuring compliance with regulations. The quality and safety of the service had not been effectively assessed and monitored, systems to ensure risks had been assessed and mitigated were ineffective, people's care records were not complete and accurate. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which

achieves good outcomes for people

- We identified a closed culture at the service which raised serious concerns about the support provided to people. A closed culture is 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm.
- During the inspection we found practices that raised concerns about abuse of people living in the service. People were not treated in a respectful and positive manner. Our concerns were shared immediately with the local authority who commenced a number of safeguarding investigations.
- Leadership in the service had been weak and had failed to ensure staff understood their responsibilities and roles. Staff did not understand what was expected of them and how to promote people's dignity.

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

- During our inspection we received information from health and social care professionals that indicated the provider was not being open and honest with people and their families regarding the significant concerns found at the inspection. This included allegations of abuse that had occurred at the service.

Working in partnership with others

- The provider worked closely with CQC and the local authority to respond to the concerns identified. They engaged in regular monitoring meetings and were keen to work with other stakeholders in order to ensure the safety of people living in the service.

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 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: People were not treated with dignity and respect. Their privacy was not maintained. Regulation 10 (1)(2)(a)

The enforcement action we took:

We served a notice of decision imposing conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: Due regard had not been given to ensuring the care and support provided was in accordance with the MCA. Regulation 11(1)(3)

The enforcement action we took:

We served a notice of decision imposing conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Actions to mitigate risks of harm to people were not effective. Not all risks to people had been assessed and considered. Medicines were not managed safely. Infection control risks were not managed. Regulation 12 (1)(2)(a)(b)(g)(h) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We served a notice of decision imposing conditions on the provider's registration.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

How the regulation was not being met:
Governance systems were not effective in ensuring compliance with regulations. The quality and safety of the service had not been effectively assessed and monitored, systems to ensure risks had been assessed and mitigated were ineffective, people's care records were not complete and accurate.

Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:

We served a notice of decision imposing conditions on the provider's registration.