Pathway Healthcare Ltd

Magellan House

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Magellan House is a residential care home. The home is registered for up to nine young people living with a learning disability and/or autism. There were seven people living at the home at the time of inspection. People had access to a communal lounge, dining area, activity room, sensory room and kitchen. People had their own bedrooms with en-suites.

People's experience of using this service and what we found
People were not always protected from abuse. Leadership was not always transparent and open about incidents that had occurred. The registered manager had not always taken action to respond and alert the local authority safeguarding team when alerted to suspected abuse.

Staffing levels were consistently below what was required to keep people safe. The registered manger and provider had not established, or implemented, appropriate staffing levels that either ensured that people were safe, or that they received the care they needed.

Risk assessments were carried out and guidance implemented for staff to support people. However, staff had not always followed this guidance to ensure that risks to some people's health was mitigated. Some people were not always provided with the appropriate diet that promoted their health and dietary needs.

Relatives gave negative feedback about the running of the service. Relatives told us they felt let down by management and provider support and that communication with them was poor. Relatives were not assured for the safety of their loved ones due to the staffing issues. Relatives said that care staff were caring in their approach to their loved ones, but that staff turnover and low staffing impacted on the support they received. Relatives stated that they did not always feel that their family members received prompt and timely support for some health matters.

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

Infection and prevention control was well managed. People received their medicines safely and the service ensured that medicines were managed well. Staff received training that was relevant to the needs of the people living at the service.

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

Based on our review of safe, effective and well-led, the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• People were not always protected from avoidable harm. There had been an increase in safeguarding incidents between people, and staff were not confident that staffing levels supported them to protect people adequately.

Right care:
• People's needs and preferences were known by caring staff, but consistent shortfalls in staffing levels meant that people did not always have access to meaningful occupation or receive the amount of support according to their assessed need. People were not always supported to maintain a balanced diet that promoted their health needs.

Right culture:
• People did not receive planned and coordinated person-centred support that was appropriate and inclusive for them. Leaders were not always transparent and did not promote an open culture at the service.

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 1 March 2019)

Why we inspected
We received concerns in relation to staffing, an increase in safeguarding concerns and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

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

Following the inspection, the provider informed us that the registered manager was not at work and that their notice period was being served. The Deputy Manager informed us they were leaving their role in the immediate future. The Head of Residential services, together with a manager from another of the providers services, was to provide on-site governance support to staff. The provider informed us that they would be reviewing actions and requirements from recent safeguarding concerns. The provider sent us staffing schedules for the following two weeks following the inspection which showed an improvement in staffing numbers, although it was unclear whether these changes was sufficient to ensure that people were receiving their assessed and funded one to one hours.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to safe care and treatment, safeguarding, staffing, duty of candour and governance at this inspection.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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 work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions 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.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Magellan 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 Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Magellan 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
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed information we had received through statutory notifications and enquiries. This is information we receive from the provider, social care professionals and the public about the service. We used all of this information to plan

our inspection.

During the inspection
We spoke with three members of staff including the Deputy Manager, Head of Residential Services and one care worker. People had different communication needs, therefore we made observations of people's support and their interactions with staff. We carried out observations of the care being provided. We reviewed a range of records. This included four people's care records and multiple medication records. We observed medication being administered. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and staff schedules. We contacted five local authority learning disability teams to seek clarification on people's support needs. We spoke to two staff members and three relatives for feedback about the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● People were not ensured safe care as there were not always sufficient staff deployed. The registered manger and provider had not established, or implemented, appropriate staffing levels that ensured that people were safe, and that they received the care according to their assessed need. Staff schedules showed a consistent level of staffing that was below what had been assessed to support people's needs effectively, and ensure they remained safe. Poor staffing levels were not found to be impacted by the pressures of COVID-19 but the failure to plan appropriate staffing levels based on lack of information about people's assessed need.

● The management and provider did not have a systemic approach, or coordinated understanding, of the levels of staffing required. Some people required different levels of funded one to one support. The registered manager had been aware of this requirement yet staffing levels on weekly schedules had not reflected this. The provider informed us that they had not been aware of any one to one hours being agreed with local authorities. This meant that people were not receiving the support they required to ensure they remained safe and well cared for.

● People sometimes displayed distressed behaviours and were a risk to themselves and others without the presence and intervention of staff. Staff members told us that they had the training to support people when expressing distress/agitation but that staffing levels did not always allow them to support every person safely. One relative said, "Residents make attachments to staff and know how to calm them down. If there is a constant stream of new staff, and they don't know the residents and the residents don't know them, then it causes anxiety."

● One staff member said, "We're so short staffed. We don't have the staff and there is a lack of one to one, as we don't have time. One to one staffing has never been confirmed by the management. I think there are four people that should receive one to one but it's hard when you don't have staff for it. We've seen an increase in behaviours, it's very noticeable for one person in particular if (the person) hasn't got staff with (the person) (they) will get violent towards staff and other people."

● Relatives provided negative feedback and highlighted concerns about their loved one's safety as a result of poor staffing levels. One relative told us, "There is a huge turnover of staff. The good ones don't stay for very long. There's not enough of them and this is where the issues stem from." Another told us, "I've phoned a couple of times in the evening and there's been no answer. It's evident that there's not enough staff there."

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action following the inspection to increase staffing levels for the two weeks following the inspection. We viewed the records that demonstrated this. Due to the providers lack of knowledge in relation to people's one to one funded support, and the feedback we received about staffing levels being low for some time, we cannot be assured that staffing levels will continue to reflect the needs of the people being supported.

● Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes were not effective in ensuring people were protected from abuse. Poor management of staffing levels meant that there were not always sufficiently deployed staff to respond to incidents between people. One staff member said, "There have been behaviours where we haven't been there, and we're taking the resident's word for it. People were saying they've been hit by other residents, but we don't know for sure because we're not able to be there. It's happening a lot. We can't cover the floor to see what's happening or what's going on, you don't know what's happened and we can't manage it."

● Relatives told us that they did not feel their relations was currently safe. One family member said, "No I don't think they are safe. (The person) followed pattern of behaviour at (their previous placement). They can be challenging. I'm seeing that same pattern now. It's worrying and it mirrors their previous placement in that staff turnover is affecting this. It's also understaffing." Another relative said about their family member, "There's issues with one other resident who can be violent. I'm not sure they are safe there."

The registered manager had failed to raise safeguarding alerts regarding allegation of abuse. The provider had failed to ensure that adequate staff were in place to ensure people were adequately protected from potential 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

● People were supported by staff who, through safeguarding training they received, were aware of the potential signs of abuse.

● Staff were confident they knew how to manage incidents properly, but current staffing levels did not always allow them to do so.

Assessing risk, safety monitoring and management

● Risks to people had not always been safely monitored. Following the inspection, we were informed that one person, who was living with diabetes, had not been supported by staff to check and monitor their blood sugar levels (BSL), according to that person's daily required need. One family member said, "A few weeks ago they had run out of test strips and couldn't take (their) BSL. They didn't tell me how long (the person) hadn't been tested for." Staff had also failed to ensure that the person's BSL was monitored according to their need in the days following the inspection, after we had been assured that staffing levels would be increased to ensure needs were met. We saw records that demonstrated this. This put the persons health at increased risk, as staff could not be assured that their BSL was within appropriate levels.

● The relative told us that control of carbohydrate input was a major factor in keeping their loved one's diabetes under control, but that staff's lack of awareness had meant this was not being supported in an appropriate way. The relative said, "They have been giving him beef stir fry with rice and noodles. Chicken burger and bun with fries. There's no controls. He's been given breakfast cereal he shouldn't be given. Staff didn't know what they were doing. You have to watch the food as the insulin is slow release." The relative

described a conversation with one staff member who said they had prepared sandwiches, crisps and chocolate biscuits for the person. When the staff member was informed by the relative of the person's Type 2 diabetes, they indicated that they were unaware they had this health condition. This put the person's health at additional risk.

The provider has failed to do all that was reasonably practical to mitigate the risks people's health and safety. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks to people were identified and assessments to guide staff were in place. For example, some people had risks associated with their mobility. There was detailed guidance for staff on how to support people which highlighted other risks posed by their health condition such as osteoporosis and epilepsy.
● Risk assessments had been completed according to people's individual needs. One person had epilepsy, an assessment identified guidance for staff on signs of potential seizures, and what physical attributes that person may display prior to having a seizure. This was to ensure that risks to that person had been mitigated as much as possible.

Learning lessons when things go wrong
● Incidents and accidents had been recorded, reviewed and monitored to determine any trends or changes to people's support.
● Records showed that incidents were reviewed by PBS leads and meetings were held to review any potential changes of support. However, staff told us that while personal behaviour support care plans were supportive in managing incidents, these could be reviewed and updated more regularly to reflect current need.
● One staff member said, "The residents are also different; we get to know the people they have PBS plans, some work, some don't always work and they're not always followed up on as quickly as you'd like." Another staff member said, "PBS plans are OK, but they need to be reviewed more regularly. For example, to remove last resort actions for people that we haven't needed to use for years it for years. We just don't have the staff to be able to keep up with it."

Using medicines safely
● Some people needed support with medicines. There were safe systems in place to ensure that medicines were administered safely. Staff had received training in administration of medicines and had regular checks to ensure they remained competent.
● Records were completed consistently and there were systems in place to monitor recording and check that people received their medicines safely.
● Care plans and risk assessments were in place for the safe administration of medicines. We observed a staff member safely administering medicines to people and in a person-centred way.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 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.

- Mental capacity assessments had not always been undertaken to determine people's capacity to consent to decisions in areas such as personal care and accessing the community.
- Senior staff confirmed that MCA's had been completed for decisions related to Covid and flu vaccines, but other MCA's, and any required best interest decisions, had not been completed for many decisions such as personal care and accessing the community. The senior staff member stated that this was an area the home needed to improve on. It was not evident that others involved in people's lives had been consulted or if decisions had been made in people's best interests.
- A senior staff member told us that people's ability to make certain decisions and how they communicated these wishes were detailed within their care plans and our inspection confirmed this. Staff had a good understanding of consent and capacity.
- Some people had conditions attached to their DoLS and records showed that these were being complied with. For example, one person required ongoing visitation with a relative which the management has facilitated.

Supporting people to eat and drink enough to maintain a balanced diet
- People's dietary needs were not always effectively met and monitored. Information about their needs was available to staff but not always known or followed. For example, one person was living with diabetes and required support to monitor their dietary input so that their diabetes remained under control. They had not always been safely supported with this and we have detailed this in the safe section of this report.
- Feedback received from relatives about how meals for people were managed was poor. Loved ones told

us that meal provision had been well managed in the past by one allocated general assistant but that a rotating duty system meant that the quality of food was variable. One relative said, "It's more hit and miss now and whether or not the staff member can cook things. It's whoever's on duty."
● People's dietary needs had been assessed and care planning reflected what support people needed to maintain these. For example, one person had a dairy intolerance and staff ensured that dairy free alternatives were offered.
● People's care plans detailed how they would communicate their likes and preferences for food through facial expressions. These also detailed what practical support people needed when eating. For example, one person used plate dividers to support staff to monitor portion sizes, while another was able to use adaptive cutlery but could communicate with staff when they needed extra support.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People did not always have timely or appropriate access to health support. Feedback from relatives was that their loved ones did not always receive effective support to ensure health concerns were addressed in a timely manner.
● One family member described how they had taken over the arrangement of diabetes appointments for their loved ones. The relative said, "Now since the diabetes, I arrange them myself. With dentist, on two occasions the staff have arrived 45 minutes late. It's not fair on (person), as he doesn't understand. It's carelessness." Another family member told us of frustrations over the home's promptness in ensuring a foot condition was addressed. They said, "(Person) suffered from bad verrucas. They said they were putting things right, but it grew. I felt I was banging my head a little. I went to a private podiatrist as it had been left too long. We had to take her and get it organised."
● Staff worked together with other professionals to ensure people had effective transitions when moving into the service. Staff would complete observations and assessments at the person's previous placement and tailor a transition plan according to that person's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices had been assessed prior to living at the home and were reviewed. Staff delivered care in line with standards and good practice.
● People's needs were assessed using evidence-based guidance to achieve good outcomes. For example, people who were at risk of malnutrition had risk assessments in place. The provider had implemented the Malnutrition Universal Screening Tool (MUST). The MUST tool enables provides to monitor people's risk of malnutrition.
● The provider had ensured that protected characteristics, such as people's religion, race, disability and sexual orientation were explored and recorded appropriately. This information was reflected and recorded in their care plans before care was provided.

Staff support: induction, training, skills and experience
● Staff completed a range of courses relevant to the needs of those people at the service. For example, positive behaviour support (PBS) training to support people with expressing emotional distress.
● New staff received an induction, mandatory training and shadowing sessions with experienced staff before they started working by themselves.
● The inspection was prompted, in part, by an increase in safeguarding concerns. We found no concerns that staff's ability to effectively support people was the result of a lack of training or skills but related to inadequate staff deployment. One staff member told us, "We would run smoothly if we had staff. The training and the support is good, there's just not enough staff."

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

● Peoples needs were met by the adaption of the building. People's rooms were decorated in colours and décor of their choosing.

● There was a separate building within the garden area which had been adapted as a sensory and relaxation area. This provided an opportunity for people to have a quiet space if they needed.

● Décor around some shared areas was minimal although this was a decision taken by the provider to ensure the safety of some people living at the service.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Governance processes were not always effective and did not always keep people safe or provide good quality care and support. Staffing levels were consistently below people's assessed needs. This meant that people did not receive the care they had been assessed as requiring to keep them safe and provide them with the care they needed.
- The governance of the service lacked a coordinated approach to ensuring people had enough staff to keep them safe. Poor communication and working between the registered manager and the provider meant that staff were unclear about what support people required. There was a significant discrepancy between the registered manager's understanding and organising of staffing levels, which they based on people's one to one requirements, and what the provider understood people's needs were. The provider was unaware that some people at the home required one to one support to keep them safe. The local authority is responsible for assessing people's one to one support needs. The registered manager failed to ensure that processes changes to people's needs and additional 1:1 support were effectively communicated. The provider is instrumental in agreeing to provide these support hours so that people receive care and support that meets their needs and which helps safeguard them when expressing when expressing distress/agitation.
- One staff member said, "The directors are doing nothing we've asked for people," and "We are getting no support at all through the whole company." Another staff member said, "One to one staffing has never been confirmed by the management I think there are four people that should receive one to one it's hard when you don't have staff for it."
- Relatives told us that they had lost trust in the management and provider. The inconsistency of, and the turnover of, managers at the service had led to a lack of confidence in the oversight at Magellan House. One relative said, "Communication is so appalling. We are on our fourth Manager. We've been totally let down." Another relative said, "We had a meeting when (person) moved in with the directors of Pathway. They don't want to get involved in what they see as the day to day. We've not had any dealings; I don't think they would be helpful. There's no relationship with Pathway at all. There's a loss of trust. They know there's an issue with staffing." One relative said, "(The registered manager) comes across as a lovely person but they haven't told me the truth. There's no transparency."

● Quality assurance and governance processes were not fully effective. Monitoring and reviews of areas such as safeguarding concerns and staffing had not been recently completed. A senior staff member volunteered that oversight of these areas had fallen behind. This meant that the management of the service could not be assured that responses to incidents had been appropriate or that any necessary changes to support were undertaken. The service had reported 24 incidents of potential abuse in 2021 and this continued shortfall in oversight placed people at continued risk of harm.
● The completion of actions from recent governance meetings had yet to be completed by management at the home, while the deputy manager was supporting senior care staff with completion of health and safety audits which had also been delayed. This meant that the provider could not be assured of ongoing quality and safety at the service.
● Feedback regarding the openness and transparency of the management team was poor. Staff and relatives told us that management were not always candid and open with relatives about incidents that had occurred or elements of their loved one's care.
● One staff member said, "Our management tone down what's going on for example for the parents, the management make out it's not so bad. They play things down. We have to be honest with people." One relative said, "The whole atmosphere changed after (previous manager) left. They haven't been accessible to residents or relatives. There's no transparency there which makes me concerned." Another family member told us, "Communication is lacking in everything. The registered manager will just fob you off all the time."
● At the time of the inspection, the registered manager was absent from the service. We were informed that the deputy manager was also leaving their role at the service. Following the inspection, we were informed that oversight of the service would be provided by the Head of Residential Services and a manager from one of the provider's other homes.
● Although staff described being supported by the registered manager and deputy manager, they told us that shortfalls in the home had affected their wellbeing and motivation. One staff member said, "The managers are supportive, they are. (The manager) has been on the phone when we've needed her." Another staff member said, "I do get management support now, but never used to. Recently they've given more support as they don't want staff to leave. So depressed at the minute which is a shame as I used to love it. Team morale is quite low, we are stressed, we're anxious about work, people call in sick all the time, it's stressful."

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some quality assurance systems had been completed regularly. The service had undertaken reviews of positive behaviour support plans and medicine checks to determine whether improvements were needed.

●The registered manager had failed to notify CQC of alleged safeguarding incidents without delay. When alerted to suspected abuse the Registered manager had not always taken action to report to the local authority in line with local safeguarding arrangements.
● One relative informed us that they had been made aware of an alleged incident of abuse between a staff member and their loved one. Although the relative had made the registered manager aware of the safeguarding incident, it had not been reported to the local authority for investigation and CQC had not been notified of the concern.

Working in partnership with others
● Staff had developed positive working relationships with a range of health and social care professionals.
● Records showed that referrals were made to specialists such as dieticians, community learning disability

teams and psychology specialists.
● The management of the service was working with the local authority to address actions required resulting from recent safeguarding concerns.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to do all that was reasonably practical to mitigate the risks people's health and safety.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had failed to raise safeguarding alerts regarding allegation of abuse. The provider had failed to ensure that adequate staff were in place to ensure people were adequately protected from potential abuse.

The enforcement action we took:

Warning Notice

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 there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm.

The enforcement action we took:

Warning Notice