Cambian Healthcare Limited

Cambian - Trent Valley Road

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected this service on 23 and 24 November 2016. This was an unannounced inspection. Our last inspection took place in October 2015. At that time we found the provider was in breach of two Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. This meant they were not meeting the required Regulatory requirements. As a result of this the service was rated at the time as 'requires improvement'.

The service is registered to provide accommodation and personal care for up to six people. People who use the service have complex needs which may include a mental health condition and/or a learning disability. At the time of our inspection three people were using the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The home manager had however applied to register with us and the process for this registration was in progress.

At this inspection, we identified a number of Regulatory breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

At this inspection, we found that the provider did not have effective systems in place to effectively assess,

monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

The provider did not always notify us of reportable incidents and events as required and the CQC rating from our last inspection was not being displayed in accordance with the law.

Risks to people's health, safety and wellbeing were not consistently identified and planned for on admission, and people did not always receive their planned care in a manner that promoted their safety.

Medicines were not always managed safely and people were not always protected from the risk of abuse as local and national reporting guidance was not consistently followed. This meant that people's safety, health and wellbeing was not consistently promoted.

There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

Staff received training to provide them with the knowledge and skills needed to meet people's needs. However, unsafe and inconsistent staffing levels meant there was a risk that physical intervention (restraint) may not always be used effectively and safely.

Independence was promoted, but some people felt that some of the restrictions placed on them at the home limited their independence at times. Some people felt they were not treated equally with the other people who used the service. This was because they felt they did not have equal access to the home's vehicle to enable them to participate in community activities in line with their individual preferences.

People knew how to complain and complaints were investigated. However improvements were needed to ensure meetings about complaints were held at people's preferred locations.

Safe recruitment systems were in place to ensure staff were suitable to work at the home. People spoke fondly about the staff. However, some people felt that recent changes at the service had resulted in staff having less time to interact with them.

Staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This meant if people could not make decisions about their care, the staff knew how to support them to ensure decisions were made in their best interests. Consent to care was sought before staff provided people with care and support.

People could access enough food and drink that met their individual preferences.

People were involved in the planning and review of their care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people's health, safety and wellbeing were not effectively assessed and planned for on admission to the home.

Medicines were not always available to keep people safe.

There were not always enough staff to keep people safe and meet peoples care needs.

People were not consistently protected from the risk of abuse and improper treatment. Potential safeguarding incidents were not always reported as required.

Is the service effective?

Requires Improvement

The service was not consistently effective. Although staff were suitably trained to provide effective care, the provider did not have effective systems in place to ensure certain parts of people's care would be carried out effectively.

People were supported to eat a balanced, healthy diet and people were supported to access health and special care professionals to support their health and wellbeing.

Consent to care was sought and respected and staff knew how to support people who could not make decisions for themselves.

Is the service caring?

Requires Improvement

The service was not consistently caring. People and staff told us that recent changes to the service meant people did not receive the same level of attention from staff that they usually received.

The provider's approach to risk management meant some people felt their independence was restricted.

Staff knew people well and supported and respected people's rights to make choices about their care.

People's privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People couldn't consistently access the community in a timely manner to participate in activities that promoted their health and wellbeing.

People knew how to complain and complaints were investigated. However, people's individual preferences about where meetings were held to discuss their complaints were not always met.

People were involved in the planning and review of their care.

Is the service well-led?

Inadequate

The service was not well led. Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm from occurring.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

The provider did not always notify us of reportable incidents and events that occurred at the service.

The provider was not displaying the CQC rating of the home as required.

Cambian - Trent Valley Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 24 November 2016 and was unannounced. The inspection team consisted of one inspector.

Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

We spoke with the three people who used the service, five members of care staff, the deputy manager, the home manager and the provider's senior homes manager. We did this to check that good standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at the care records of the three people who used the service to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, staff rotas and training records.

Inadequate

Is the service safe?

Our findings

At our last inspection, we told the provider that improvements were required to ensure safe staffing levels were maintained. This was because staff were not always available to provide people with safe, prompt care and support. At this inspection, we found the required improvements had not been made.

People who used the service and the staff told us one person who used the service needed the support of three staff to safely manage their behaviours that challenged. This person's care records also confirmed that three staff were needed in the event of physical intervention (restraint) being required. Staff told us the importance of having three suitably trained staff members available so that safe restraint could be completed if required. One staff member said, "We need three to do physical intervention. If there was only two of us, we would just have to back off and phone the police for help". Another staff member said, "Safety wise, we need a minimum of three. It's a position I don't like to be in, just having two staff". People and staff told us that there were occasions where just two staff were on duty. Staff rotas showed that in the 14 nights leading up to our inspection there were four occasions where just two staff were on shift. This meant that on those four nights safe staffing levels had not been maintained and there was not enough staff available to ensure this person's care plan could be safely and effectively followed if a safety incident had occurred.

People told us that recent changes to the service had meant staff were not always available to support them when they needed support. One person said, "The staff used to engage with us more before (the recent changes). It's meant sometimes there's no one around". Another person said, "Staffing isn't the greatest at the moment. If [person who uses the service] wants to go out, they go out with two staff in the van. That leaves one staff member and no van for me and [another person who used the service]. This person gave us an example of how the recent changes had affected their ability to do the activities they wanted when they wanted to do them. Staff confirmed that recent changes had meant they were not always able to offer everyone the support they needed. One staff member said, "Sometimes one person who uses the service takes all our time and effort. We try and make time for the other two who are more independent, but what happened to treating people equally?". Another staff member said, "The young people miss out on our attention sometimes and it's starting to show in their behaviours now".

Following our inspection the home manager sent us information about the staffing levels at the home. This information stated that staffing levels were assessed on a daily basis and when risks had reduced the staffing levels reflected this. However, the care records of the person who required three staff at times, showed that their risk of self-harm, violence and aggression remained high during the times where staffing levels reduced to two at night. This showed that the staffing levels did not reflect this person's safety risks.

The above evidence shows that effective systems were not in place to ensure safe staffing levels were maintained to consistently promote peoples safety and meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we told the provider that improvements were required to ensure that safeguarding concerns were promptly referred to safeguarding teams to promote people's safety. At this inspection, we

found that improvements were still required to ensure all safety incidents were appropriately and promptly reported.

Although staff showed us they had a good understanding of children and adult safeguarding procedures, we found that a recent safeguarding incident had not been promptly reported to the safeguarding team as required. The home manager had reported the incident to a health and social care professional who had previously been involved in the alleged victim's care, but had not directly shared the information with the safeguarding team. This meant the correct safeguarding referral process had not been followed as required by the provider's safeguarding policy and national safeguarding guidance. The home manager also shared information about the incident with the alleged abuser's health and social care team who proceeded to contact the police. This resulted in the police visiting the home to interview the person and they had now become the alleged abuser rather than a victim. This caused the person agitation and distress which we saw was ongoing during our inspection. Not referring the incident immediately to the safeguarding team when it was disclosed by the alleged victim meant they were treated as an alleged abuser rather than a victim.

This showed safeguarding concerns continued to not be consistently reported in accordance with national and local guidance as required. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we told the provider that improvements were needed to ensure medicines were managed safely. At this inspection, we found further improvements were still required.

Prior to being formally admitted to the service, one person stayed at the service for at least 10 nights in the seven weeks leading up to their admission. This meant they had received care and support from the service before their formal admission to the home. On one of these pre-admission stays the person arrived at the home without their prescribed 'as required' medicines. The home manager told us they immediately contacted the staff where the person was formally receiving their care at the time to ask for the medicines to be delivered to them. The other service agreed to drop these medicines off in two days' time. This meant the person's 'as required' medicines were not available should they have needed them during this time. The home manager confirmed no risk assessment was in place to manage the risks associated with this medicine not being available. This showed effective systems were not in place to ensure the medicines people were prescribed were readily available at the home.

Accurate medicines administration records (MAR) were not maintained. One person's MAR showed they needed one of their medicines to be administered at 6pm. Staff told us this medicine was prescribed to have a sedative effect on the person. The deputy manager told us this 6pm dose had been stopped by the person's GP. This meant the MAR was not up to date and the person was at risk of receiving a medicine that they were no longer prescribed. Although permanent staff at the home were aware of this change, there was a risk that temporary staff working at the home would not be aware of this change. This risk was increased as there was some staff movement between the local homes owned by the provider to cover staffing issues.

We found that risks to people's safety and wellbeing were not always assessed and planned for on admission to the home. One person who was admitted to the service did not have a care plan devised until six days after they were formally admitted to the service. Staff told us they followed the care plan and risk assessments from their previous placement during this time. However, the care plans and risk assessments from the person's previous placement did not address the specific risks that were present at Cambian - Trent Valley Road. For example, the person's previous placement was a locked unit and Cambian - Trent Valley Road is not. The risk of the person leaving the home unsupported had not been assessed and planned for. A plan was only put in place to manage this risk after an incident where the person left the

home unsupervised and acquired medicines which they later took in a medicines overdose. This meant the person's safety and care needs specific to their placement at this home had not been formally assessed and planned for prior to or on their admission to the home. This resulted in harm to the person's health, safety and wellbeing.

We found that most people's risks were being appropriately managed and reviewed in a prompt and effective manner. However, we found risks management plans were not consistently followed and care was not always delivered in accordance with the agreed care plans. For example, one person's care records stated that staff should follow them if they left the safety of the home. Incident records showed that in the two weeks leading up to our inspection this person had left the home and were not followed by staff as planned. When we spoke with staff about this person's care plan we were told inconsistent information. For example, one staff member told us they would not follow the person as they felt this would cause their behaviours to escalate. However another staff member told us they would follow the person as planned. This meant the person had received and was at risk of receiving inconsistent and unsafe care. This placed them at risk of harm to their health, safety and wellbeing.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe around the staff. We saw that safe recruitment systems were in place that ensured staff were of suitable character to work with vulnerable children and adults.

Requires Improvement

Is the service effective?

Our findings

People told us the staff had the skills they needed to work effectively with them. One person told us how staff had the right skills to help manage their behaviours that challenged. They said, "They try to de-escalate me verbally before they start restraint. Even in restraint, they keep talking to me and they check I'm okay after". Staff told us and records showed that staff had received training to equip them with the skills needed to manage behaviours that challenged and to use physical intervention effectively. One staff member said, "Physical intervention is always a last resort. I haven't needed to use it as I've always been able to calm people down verbally. I know how to use the techniques if I did need to use them as I've had the training". However, the provider did not ensure suitable staffing levels were consistently available to ensure physical intervention could be carried out in an effective and safe manner. This meant that although staff were suitably trained to enable them to support people with behaviours that challenged, the provider did not have systems in place to ensure this intervention was completed in a safe and effective manner.

Some staff told us they had regular meetings with the manager where they talked about their training needs. One staff member told us how they had been placed onto a training course to help their development. They said, "We talked about how I wanted to progress in the company and I've been put on a team leaders course so I can progress".

People told us they could choose the foods they ate. One person said, "We have a meeting every Sunday where we talk about the meals for the week. We take it in turns to cook. If I didn't want what was being cooked, I can something different". Another person told us how they could choose to cook and eat with others or on their own. People told us that a healthy, balanced diet was promoted. One person told us they could snack on fruit if they were hungry between meals. Another person told us that they wanted to lose weight and staff were supporting them to eat a healthy, balanced diet in order to achieve this. We saw that people could access the kitchen for food and drink at any time.

People told us they were supported to stay healthy and had access to a variety of health and social care professionals. One person said, "If I need a doctor or dentist, the staff will ring them for us. They try and get me to do this myself too so I become more independent". Care records showed people were supported to receive assessment and support from health care professionals' including; GP's, psychologists and occupational therapists. We also saw that staff responded to urgent changes in people's health promptly. For example, one person's records showed that an ambulance was requested in response to a medical emergency and on another occasion the person had been supported to visit the local walk in centre in response to a less urgent change in their health.

People told us that staff respected their right to make decisions about their care. One person said, "I don't have to do anything I don't want to do". Staff told us that all the people who used the service had the ability to make everyday decisions about their care and treatment. They also told us they had to respect any potentially unwise decisions that people made if they had the capacity to understand the consequences of these decisions.

Staff showed they understood the principles of the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff understood that the Act only applied to people who were 18 years old and over. They also showed they understood the rights of children in making decisions about their care.

Adults can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff showed they had a good understanding of DoLS. At the time of our inspection, no one was being deprived of their liberty; therefore no DoLS authorisations were in place.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person said, "The staff are pretty great. They are supportive and very compassionate. When I have a problem they don't laugh, they take it seriously". Another person said, "The staff are okay, we get on and have a laugh". However, people also told us that due to recent changes at the home, the staff were often very busy which meant they didn't get the level of attention and support they usually received. One person said, "This place used to be a lot happier. The staff seem stressed out now". Another person said, "We don't get as much time with the staff now". Staff confirmed that they were now able to offer people less support at certain times due to recent changes at the home.

People and staff also told us that sometimes permanent staff at the home were being moved to work at other local services owned by the provider. This meant staffing gaps at this service were filled with temporary agency staff. One person said, "Sometimes we get staff here who I don't know. I just go to my room when that happens". A staff member said, "Reliable staff from here are moved to other houses and then they bring in staff here who the young people don't know. They expect them to be fine with it, but it causes tension". One person's care records contained a concern that had been shared by their social worker to the manager of the home. This concern stated that they had noted an increase in the use of temporary staff and staff changes which was making the person distressed and posed a potential trigger for anxiety. This meant some disruption and unsettlement was caused to people who used the service when the provider moved permanent staff to work at other local services.

People told us their independence was promoted. One person said, "Living here has made me independent. It makes me feel good". Another person said, "They try and make me more independent". However, people also told us that some restrictions in the home made being independent difficult sometimes. One person said, "Sometimes it feels like a hospital. Everything's locked away, I even have to ask for a potato peeler". "Staff say it's a risk, but it's not a risk for me". People who don't need to be in hospital should be able to have access to these things". This person told us staff couldn't always get them the equipment they needed promptly if they were busy with other tasks. They explained that this had an impact on their ability to be as independent as they would like to be. This person's care records showed no risk of self-harm or aggression to others. This meant their ability to be independent was being restricted by the provider's approach to managing risk at the home.

People told us they could make choices about their care. For example, one person told us they decided they had recently chosen not to go to college for a full day as planned. They told us that staff encouraged them to go, but respected their decision not to. This showed staff supported and respected people's rights to make decisions about their care.

People told us the staff knew them well. One person said, "They know I like animals. They talk to me about them and we go to the zoo or farm to see animals". Staff told us about people's likes and dislikes which showed they had the information they needed to have meaningful interactions with people.

People told us their right to privacy was promoted and respected. One person said, "They always knock on

my door and they don't come in until I say they can". One person who used the service required one to one support from the staff. They told us staff provided this support in a respectful manner. They said, "Sometimes it feels intrusive, but I understand why it's needed".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we told the provider that improvements were needed to ensure people could consistently participate in the activities of their choosing. At this inspection, we found that improvements were still needed to ensure people could participate in activities that met their individual preferences at their preferred times.

People and staff told us that due to the recent changes at the service one person could spend long periods of time out accessing the community in the home's vehicle. This meant other people at the service couldn't always access the community using this vehicle as readily as they were accustomed to. One person told us of an occasion where they hadn't been able to access an activity that was important for their mental wellbeing in a timely manner, as they had been told they needed to wait for the vehicle to be returned to the home. Although people were encouraged to be independent and use public transport, public transport was not always available. Staff confirmed that one person who used the service did have more use of the home's vehicle than the other two people, which meant at times people were not treated equally.

We shared our concerns about this with the home manager at the end of our inspection. Following our inspection the home manager and provider sent us a written response to these concerns. Part of their response stated, 'Each young person has to consider that they live in a house with other young people and that there is only one vehicle'. They described these limitations at the home as a 'normal family consideration and helps the young people to consider other people's needs and learn to compromise'. Being able to access activities that help people to manage their wellbeing in a timely manner is an important aspect of care and support. When this access is limited or restricted there is a risk that people's mental wellbeing with suffer.

People told us and we saw that they knew how to complain about their care. We found that complaints were investigated. However, improvements were needed to ensure people received feedback about their complaints in a manner that met their preferences. One person told us and records showed they had complained about their care and support. They told us they had met with the senior homes manager to discuss their complaint. However, they hadn't received an outcome or feedback after the meeting. The senior homes manager told us the person declined to attend a further follow up meeting to discuss the outcome of their complaint. The person told us they had declined this meeting as they were asked to travel to another location owned by the provider approximately 20 minutes away. They told us they had informed the provider of this and they said they would have preferred to have this meeting at their home. The provider told us the meeting could not be held at Cambian - Trent Valley Road because of safety concerns. This meant that on this occasion the person's individual preferences had not been met.

People told us they were regularly involved in the planning and review of their care. One person said, "I look at my care plan every month. Sometimes it's in a key worker session, sometimes it's in a STAR meeting (people described these meetings as goal setting meetings)". Another person said, "I've seen my care plan, it has what I like in it. We have meetings where we talk about the care plan, how they can support me and what's going well". This showed people contributed to the planning and review of their care.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that effective management systems were not in place to ensure quality care was provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

After our last inspection, the provider sent us an action plan outlining how the required improvements would be made. We found this action plan had not been effective as the required improvements had not been made as planned. For example, we told the provider that minimum staffing levels were not consistently maintained, and we found this was still an issue at this inspection. This showed the provider had not made or sustained the improvements needed to ensure care was safe, responsive and well-led.

The home manager and deputy manager told us that new systems had been put in place to assess and monitor the quality of care. However, they told us they had not had training or support to enable them to use these new systems effectively. We saw that some of these systems were not effective in assessing and improving quality. For example, we were shown a self-evaluation form that had been completed by the deputy manager. This tool was used to identify if people who used the service were experiencing a 'good' standard of care that met the Regulations. We saw and the deputy manager confirmed that they had completed the evaluation without asking people about their care experiences, despite the tool focusing on people's care outcomes. For example, one of the questions stated, 'Young people report that staff are consistent and clear about the management of all behaviour and expectations'. The deputy manager confirmed they had not asked for people's feedback about this, yet they had concluded that the home was meeting this standard. They said, "I wasn't sure how to complete it, I've not been trained in how to use it yet". This showed the tool was not being used effectively to gain accurate feedback from people about their care experiences.

We were given another completed self-evaluation form on the second day of our inspection. We noted the format of the tool had changed slightly from the previous one. We could not be assured that this amended tool was effective in assessing quality as it appeared to contain an inaccurate reflection of the quality of care. For example, one question stated, 'When young adults are new at the home, staff plan well and anticipate issues'. The deputy manager had concluded that the staff were meeting this standard. However, the newest person admitted to the home did not have a specific care plan or risk management put in place for this placement until six days after their admission. The plan was also only out in place following a safety incident, which meant staff did not effectively plan and anticipate the issues relating to this person's admission to the home. This showed this tool was being used ineffectively.

We found that where problems with care had been identified through this self-evaluation, no action plan was in place to drive improvement. For example, the deputy manager had identified that people who used the service were not often involved in the staff recruitment process as interviews were often held when people were at college. No plan was in place to make changes to address this.

An audit of medicines management had not been completed since 2 September 2016. This meant the safety

concerns related to medicines management had not been identified by the provider. The management team told us they were unsure of these medicines audits needed to be completed as new audit tools had been introduced at the service. This meant regular audits of medicines management were not being completed to enable the provider to identify and act upon safety concerns.

The above evidence shows that effective systems were still not in place to ensure the quality of care was effectively assessed, monitored and improved. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that the provider did not consistently notify us of reportable incidents as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found we had still not consistently been notified of reportable incidents as we identified that we had not been notified of two incidents of alleged abuse as required. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The manager told us they had learned from these errors and would notify us of future reportable incidents as required.

On 1 April 2015, it became a legal requirement for provider's to display their CQC ratings for their registered locations. We found that the rating from our last inspection of Cambian-Trent Valley Road was not being displayed as required. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager at the home at the time of our inspection. However, the home manager had applied to register with us. People and staff gave us mixed views about the management of the home. Some people felt the management team were friendly and approachable and some people felt the management team were ineffective and unsupportive. Some staff also described a disconnect between them and the management team which caused them frustration at times. An example was given by one staff member where they had received emails informing them of improvements they needed to make rather than being told face to face by the management team. This meant some people and staff felt unsupported by the management team at times.

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 We found we had still not consistently been notified of reportable incidents as we identified that we had not been notified of two incidents of alleged abuse as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments We found that the rating from our last inspection of Cambian-Trent Valley Road was not being displayed as required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure people consistently received their care in a safe manner.

The enforcement action we took:

We served a warning notice to the provider informing them that they needed to make immediate improvements.

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 Safeguarding concerns continued to not be consistently reported in accordance with national and local guidance as required.

The enforcement action we took:

We served a warning notice to the provider informing them that they needed to make immediate improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were still not in place to ensure the quality of care was effectively assessed, monitored and improved.

The enforcement action we took:

We served a warning notice to the provider informing them that they needed to make immediate improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective systems were not in place to ensure safe staffing levels were maintained to consistently promote peoples safety and meet people's needs.

The enforcement action we took:

We served a warning notice to the provider informing them that they needed to make immediate improvements.