Suncare Recovery Limited

Two Rivers Care Home

Inspection report

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Ratings

Overall rating for this service

Is the service safe?

Is the service effective?

Is the service caring?

Is the service responsive?

Is the service well-led?

Summary of findings

Overall summary

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.

About the service

This service is jointly registered as a residential care home and a domiciliary care service, which provides care to people living in supported living services. The residential part of the service is called Two Rivers and is registered to provide personal care and accommodation to 8 people. The care home is a house with a garden and access to the high street.

The supported living service supports 15 people in three shared houses. In each shared house people share the kitchen, lounge, and some bathrooms. There is sleep in staff and an awake staff who monitors the CCTV footage in people's bedrooms and lounges from the residential part of the service. The services purposely supports Asian women who have learning disabilities, physical disabilities, and who are autistic.

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

Right Support:

People at times did not receive safe care. Risk assessments and care plans did not explore and explain fully what people's needs were and how they should be supported by staff. When people moved to the service this was not completed in a planned, safe, and thoughtful way. Staff were not well trained to understand people's needs outside of their personal care needs and to know when they needed to advocate for people. There was a lot of surveillance and restrictions in place which could undermine people's rights and choices. People saw health professionals frequently to support with their health needs.

People were not supported to have maximum choice and control of their lives and managers, the provider 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.

Right Care:

Work had not been completed to look at people's life goals, their interests and what they found fun as individuals. No plans were made to try and make these goals and what people enjoyed happening. Some staff were thoughtless towards some people, and they did not promote the home as people's own space.

People had blanket routines such as what they ate, what they did, and when they went to bed rather than look at what individuals wanted to do and to make these routines happen. Some staff were thoughtful towards people, but people were not always being treated as adults. People ate nutritional food cooked by staff which people said they liked. But routines meant people could spend a long time in bed without access to drinks and on their own. People's religious cultural needs were promoted at the service.

Right Culture:

The leaders of the home had not created a culture which established a safe and person-centred experience for people to live in. The provider was not effectively assessing the quality of the care at the home. They were not looking at what people's experiences were like and considering what else could be done to reduce restrictions and make life more enjoyable. The provider and managers had made some improvement to processes to promote people's safety and had started looking at staff skills and support following our feedback. But there was a lot to do, and more time will be needed to improve the service.

Based on our review of safe, effective, caring, responsive and well led the service was not able to demonstrate they were meeting the underpinning principles of right support, right care, right culture (RSRCRC).

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 31 May 2023).

Why we inspected

The inspection was prompted by a notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk and dignified care. This inspection also examined 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.

Enforcement and Recommendations

We have identified breaches in relation to people's safety, management's response to safeguarding concerns, restrictive practices and the application of the mental capacity act, person-centred care, promoting privacy and dignity and failures in the leadership of the service 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 have requested an urgent action plan from the provider to understand what they will do to improve the

standards of quality and safety at the service. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

Care Quality Commission

Two Rivers Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 completed by 2 inspectors 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
This service provides care and support to people living in 3 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Two Rivers 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. Two Rivers 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
We used the information the provider sent us in their current provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed the information we held about the service and sought feedback from the local authority.

During the inspection
We completed 3 site visits at the residential part of the service including an evening visit. We also visited the supported living service shared houses to talk with people and staff. We spent time in the service to see how people were treated and what their days and evenings looked like. For the care home we also assessed the accommodation. We reviewed 11 people's care records, including their risk assessments, care plans, reviews, health records, daily checks, other plans, and documents related to their mental capacity and DoLS. Fire safety records were reviewed. A count of medicines took place and people's accompanying medicine records were reviewed. Staff recruitment checks and training records were reviewed. We spoke with 6 people's relatives, 9 staff, the deputy managers, registered manager, and acting manager and 5 people. We also spoke with 2 professionals.

Inadequate

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
● A person had experienced degrading treatment. They had also been put at risk and experienced an injury.
● We found examples of institutionalised practice, such as blanket routines, surveillance, and information displayed to benefit staff rather than people.
● There were poor systems and poor safeguarding knowledge by the provider. Safe systems to respond to a local authority safeguarding investigation were not in place.

This had placed people at risk 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
● A person who was at risk of choking and who had been assessed to have a specialist diet by a health professional was being supported to eat at pace and in an unsafe way on two occasions by staff.
● Risk assessments did not explore all the risks which people faced. They were often generic and not personal to the person.
● Risk assessments also lacked detail and staff did not have access to effective care plans to support their practice.
● When people returned from long hospital stays or moved from the residential part of the home to the supported living service, full risk assessments and care plans were not completed.
● There was no system to follow up on incidents and accidents. There were no checks when incidents happened staff had responded appropriately.

Preventing and controlling infection
● We observed poor infection protection control (IPC) practices from staff.
● Faecal matter was found on a person's made bed. Some people's incontinence products had been taken out of their packaging, sometimes exposed close to open windows.
● There were dents on the banisters and walls which is an IPC risk as these areas cannot be kept clean.

Using medicines safely
● A person's medication administration record (MAR) gave different advice to the person's care plan on how to administer a particular medicine. This could lead to a member of staff following the wrong instructions.
● Staff prompt cards for people's medicines were not up to date with what medicines some people took.
● When people's care plans instructed staff to give people their medicines at the correct times these 'correct

times' had not been obtained and clarified.
● We completed a medicine count for 4 people's medicines, most medicines remaining tallied with what had been given, but 1 person's medicines did not, and this could not be explained.
● The key and safe code for some people's medicines were not kept in secure places.

All of these issues had placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they liked the staff who cared for them. One person said "Happy" when we asked them. Another person told us, "I like it here."
● People's relatives did feel their relatives were safe at the home and at the supported living service. One person's relative said "[Name of person] is quite happy there and that gives us relief." Another person's relative told us, "We have no issues with safety, [name of person] is fairly well looked after."

Staffing and recruitment
● Staffing levels were not sufficient to support people at night who were awake or wanted to be awake.
● Confirmation of staff identities and references were sought. However, there was no recording that identifies and references had been verified.
● Staff had DBS (Disclosure and Barring Service checks) completed before they started working at the home and the supported living service to try and keep people safe. Gaps in employment had been explored.

Learning lessons when things go wrong
● Due to a lack of effective processes and leadership at the service, there was not the opportunity to learn from mistakes.
● The deputy managers and provider were receptive to our feedback and addressed some issues quickly such as the issues with medicines, incident reporting and a lack of a person-centred environment.

Visiting in care homes
● Relatives told us they were free to visit whenever they wanted to.

Inadequate

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.

Staff support: induction, training, skills and experience
● We observed poor staff practices in relation to treating people in a person centred and thoughtful way, supporting people to access their home, use the stairs safely, eat safely and engage with people at these times safely. These were all indicators of poor staff training and support.
● Some training was out of date or not happening at all, this included first aid training, the manager and providers had not identified this issue until we had pointed it out to them.
● The training provided support to people with a Learning Disability and autistic people was not adequate to fully meet these associated needs.
● Deputy managers had not had supervision for some time. One new manager had been tasked to reassess a person's needs when they returned to the service, without the training, support, or any sign off to do this task.
● Apart from medicine administration staff did not receive competency checks from the managers or provider to check the training was effective. Following our feedback this had started.
● The provider had changed the presence of awake staff in the home without considering how some aspects of safety monitoring at night would take place in the supported living services. There was insufficient staff deployed to ensure people needs were met.

This had 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.

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).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.
● The registered manager and provider were not compliant with the MCA. There were examples of restrictions which had not been reviewed effectively to see if these were the least restrictive option.
● Some people did not have access to their clothes. A person had a tray table attached to their wheelchair which a professional had arranged, no one had considered this was a restriction. Staff had also kept the tray table attached well after lunch had finished.
● CCTV cameras were in operation 24 hours daily, with no consideration during personal care times, when people were amongst staff in the lounges, and when some people did not need this level of monitoring.
● People who were funded to receive one to one care were receiving this care in an overly restrictive way. People did not have access to parts of their home when they wanted to.
● Some people's relatives were making decisions on their relative's behalf without the legal authority to do so. Deputy managers understanding of power of attorney and court of protection was not sufficient to promote people's rights regarding this.
● When best interest decisions were made, correct best interest processes were not being followed.

This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People did not have risk assessments and care plans in line with standards and best practice guidance.
● Parts of the home were adapted to improve people's experiences of living there. But deputy managers, staff, and the provider did not always utilise these adaptions. For example, supporting people to access the garden, even on a warm sunny day.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff were not knowledgeable about what some people's specialists' diets were, who were at risk of choking. They did not have access to people's current guidelines from food specialists.
● Some relatives were concerned people could be hungry and thirsty in the evening as dinner was at around 17:00 and people went to bed early. We also raised this with the registered manager and provider.
● People were supported to eat a nutritional diet which followed their cultural dietary needs. A person said, "I like Indian food." A person's relative told us, "[Name of person] has Asian orientated food, [name of person] enjoys that."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to see health professionals such as GPs, psychiatrists and dentists regularly.
● A person's relative said, "In terms of sickness and health they [staff and managers] are very good in that regard."
● Managers worked with other professionals from the local authority. However, there were missed opportunities to advocate for some people's rights at times and consider other expert support and advice.
● Some people's relatives felt staff needed more support to contribute to professionals' meetings.

Inadequate

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 always treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence
- A person was treated in a degrading way by a member of staff. Other staff did not challenge this issue.
- Personal information was displayed on laminated posters in people's bedrooms; this was for the benefit for staff not the person themselves. Incontinence items were stored on display in people's bedrooms.
- When a person was supported to talk with their relative via facetime this happened in the lounge among other people and staff.
- There were missed opportunities to promote people's independence in the supported living service to complete daily living tasks and create plans to support people to live more independently.

Ensuring people are well treated and supported; respecting equality and diversity
- Staff were seen to roughly wipe people's mouths after mealtimes in communal spaces, staff did not explain they were going to do this to people. Toilet times were announced by some staff in front of other staff and people.
- Staff, managers, and the providers did not always respect the home as people's own home. Some staff did not allow some people to access different parts of their home.

Supporting people to express their views and be involved in making decisions about their care
- People were not being offered individual choices and opportunities to express their views.
- There were blanket routines such as times to go to bed and meal choices. Routine group events as opposed to individual events, only took place.

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

- When we saw poor staff practice we did not believe this was the result of staff being intentionally unkind, but a result of the lack of training and support staff had received from managers, registered manager and the provider.
- When staff interacted well with people, we saw people smiled and they looked happy.
- One person said, "Staff are nice." People's relatives said they were confident staff were kind and caring. A person's relative told us, "They're kind staff." Another person's relative said, "They [staff] are kind and caring and they speak to her in her mother tongue which makes her happy."

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

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
● Staff, deputy managers, the registered manager, and the provider did not try and identify and promote what people liked to do. People did not have personalised plans which explored their interests and made goals to try and achieve these.
● When some people expressed a particular interest, staff and managers did not take advantage of this opportunity to help people fulfil these and consider how these interests could be achieved.
● Planned events were walks to the local park, bus rides sometimes to no destination or to go to Brent Cross, and swimming which was seasonal. But few other options were provided. Events were group events not individual ones. We were told this was because of the staffing levels.
● When 'activities' were planned in the home these were described as something they were not. We were told one afternoon an activity of head massages and feet massages was happening. But this isn't what happened. People had their feet creamed with their prescribed creams and staff re-braided people's hair. Staff were not trained to provide the activities offered.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Daily routines were institutionalised so everyone ate at the same time and went to bed at the same or similar times. When we visited the care home one evening everyone was in bed by 19:30 most were awake. No evening events or social time was being offered.
● Care plans did not show people were being involved in their care decisions or efforts were being made to do what the person wanted to do.

This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's cultural and religious needs were explored and supported by staff and the deputy managers.

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.
● The registered manager had considered people's communication needs in people's care plans, but these

were not being reviewed effectively to see if staff could do more here to understand what people were communicating.
● Staff spoke English and different Indian languages such as Gujarati to help people understand what they were saying.

End of life care and support
● This important aspect of people's lives was not being considered at all. There was no evidence to show staff were trying to make plans and have conversations about this with people and their relatives. This included people who had conditions which could be fatal and sudden.
● People's relatives confirmed to us these conversations were not happening, some thought it would be a good idea if they did.

Improving care quality in response to complaints or concerns
● The registered manager and provider had responded to a relative when they raised issues. A meeting was held, and a plan was made.
● People's relatives said they felt confident raising issues if they needed to. A relative said, "The Managers are approachable, and I'd have no problem complaining if I needed to and it's dealt with quickly."

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 our last inspection we rated this key question requires improvement. 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
- The registered manager and provider did not know about RSRCRC and they had not implemented these values into the home and supported living services.
- They had no effective quality monitoring systems to test the quality of the care provided. The audit they did complete was irregular and limited in scope, which captured no evidence to show how they had conducted their audit.
- Nor had they questioned some aspects of staff practice, when supporting people with aspects of their personal care, which had become routine, even when it could put people at risk of harm.
- There was a lack of robust leadership day to day with a deputy manager covering the whole service, despite working hard, they were often stretched and unable to spend time with people and staff, to monitor and develop the care delivery.
- The registered manager and provider had created a management model which did not ensure staff practice, risks, and people's daily life experience was being thoroughly checked and assessed. This put people at risk of experiencing abuse and harm.
- The registered manager and provider had not ensured all important events such as a serious injury and a safeguarding referral to the local authority, were shared with the CQC in a timely way, and was only shared when a professional prompted them. Even though they were required to do so by law and we had told them to do this at previous inspections.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
- The home and supported living service was institutionalised in many ways. In how it managed risks, promoted people's freedoms, and created opportunities for people to find things they enjoyed and to have fun.
- The registered manager and provider had not ensured staff were well trained and supported to contribute to people having a positive person-centred experience.
- The registered manager and provider had not been open with their internal reporting and investigation when a person experienced harm.
- The registered manager had not followed the provider's own policy when accessing CCTV footage remotely and did so in a way which made staff feel overly observed.
- All of these factors created a closed culture at the service.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was also a breach of registration regulation 18 (Notification of other incidents) of the (Registration) Regulated 2009 (Part 4).

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not fulfilled their duty of candour when something went very wrong.
● 2 people experienced inadequate care with 1 experiencing an injury. The provider had not followed a formal process. Providing a formal apology with an explanation of how they would ensure this would not happen again.

This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others
● The registered manager and provider had not created systems or a culture to promote learning and the continuous improvement of the care provided.
● The deputy managers had worked with health professionals to meet people's health needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● When reviews of needs and the care people received took place there was no information to show people had been involved as much as they possibly could. Or to show staff who knew them well, relatives and professionals, had also contributed to these reviews.
● Staff, deputy managers and relatives were not being included in the development of the home and supported living service.

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 Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems, care planning and practices had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had experienced degrading treatment and restraint. Appropriate action was not taken when potential neglect or harm occurred. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered manager and provider did not fulfil their duty of candour when something went wrong.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive adequate training to meet people's needs and promote their lived experiences.

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 Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not being consistently treated in a person-centred way. This placed people at potential risk of harm in relation to their mental health.

The enforcement action we took:
We issued a warning notice highlighting this breach to the provider and warning if they are not compliant at the next inspection we may take further enforcement action. We issued a date the provider must be compliant by.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were at times were not treated with dignity and respect. People's privacy was not always promoted.

The enforcement action we took:
We issued a warning notice highlighting this breach to the provider and warning if they are not compliant at the next inspection we may take further enforcement action. We issued a date the provider must be compliant by.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a culture of surveillance and excessive monitoring of people. Restrictive practices had not been effectively assessed to confirm if these were proportionate and appropriate.

The enforcement action we took:
We issued a warning notice highlighting this breach to the provider and warning if they are not compliant at the next inspection we may take further enforcement action. We issued a date the provider must be compliant by.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were key shortfalls with how the provider and the registered manager assessed the quality of the care provided at Two Rivers. Robust systems had not been established which were used to effectively assess and monitor the standard of care at the home. The management structure was not effective in assessing risks and ensuring people had positive experiences living at the service. of This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice highlighting this breach to the provider and warning if they are not compliant at the next inspection we may take further enforcement action. We issued a date the provider must be compliant by.