Little Oyster Limited

Little Oyster Residential Home

Inspection report

Seaside Avenue
Minster-on-Sea
Sheerness
Kent
ME12 2NJ

Tel: 01795870608

Date of inspection visit:
23 February 2022
24 February 2022

Date of publication:
02 August 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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.

About the service
Little Oyster Residential Home accommodates up to 64 people across three buildings. The main building is divided into two floors and an annex (which had been renamed Sea Breeze and Sea View), and there are separate bungalows and apartments where people live more independently. The service accommodates people who have learning disabilities, mental health conditions and physical disabilities. The service was providing personal care to 42 people at the time of the inspection.

People's experience of using this service and what we found
Most people told us the service had made improvements since July 2021. They told us this had led to improved experiences for them. Some people had not had the same improved experiences and improvements had not been embedded in every area of the service.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support
Staff did not provide effective support to identify people's aspirations and goals and assist people to plan how these would be met. Staff did not always focus on people's strengths and promoted what they could do. There was not a consistent approach to supporting people to learn new skills or maintain their skills for as long as possible, where this was appropriate.

The service had systems and processes in place to safely administer and record medicines use, however these were not always followed. Medicines were not always administered in line with the prescription. Some medicines with additional administration or safety requirements had not been properly identified and addressed in people's care plans or risk assessments.

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

The service provided people with care and support in a clean and well equipped environment. The service was undergoing a programme of redecoration and repair. However, some safety aspects had not been identified and mitigated prior to the inspection. The risk to people from hot, uncovered radiators and risks

arising from people's diagnosed health needs had not been addressed.

Right Care
People's care was not always person centred and did not always meet their assessed needs. Care plans and risk assessments contained conflicting information. People's preferences had not always been recorded which meant people did not always receive care as they would like. Some people experienced delays in receiving care when they needed it because call bells were not always answered in a timely manner and people living in the apartments outside of the main building experienced delays because staff assigned to work with them were also assigned to work in the main part of the service.

Although most people received improved experiences in relation to their dignity, respect and human rights, some people did not feel treated with dignity and respect.

Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had enough staff to meet people's needs and keep them safe. However, Staff had not always had the necessary training to meet people's assessed needs.

Right Culture
Since the last inspection, people, their relatives and staff had been encouraged and supported to provide feedback about the service. Most people felt listened to. Three people did not always feel the same, one person had been asking to move bedrooms and had not been listened to. Complaints made to the service had not been responded to in line with the providers policy.

The provider's quality monitoring processes had not always identified concerns and improvements in the service. The management team were still in the process of embedding changes, providing mentoring, support and coaching to staff to understand the importance of recording.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 06 October 2021). The provider was found to be in breach of Regulation 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was no longer in breach of some regulations. Improvements meant that breaches of regulations 13, 14, and 15 had been met. However, the provider remained in breach of regulations 9, 10, 11, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This service has been in Special Measures since 06 October 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement and Recommendations
We 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 monitor the service and will take further action if needed.

We have identified continued breaches in relation to: risk management, medicines management, staff training, ensuring consent to care and treatment in line with law and guidance, ensuring people received person centred care and support, treating people with dignity and respect, management of complaints and ensuring systems and processes are operated effectively to assess, monitor and improve the quality and safety 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 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Little Oyster Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
This inspection was carried out by four inspectors (including a medicines inspector) and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Little Oyster Residential Home 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. Little Oyster Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of the inspection, there was no registered manager in post, however the nominated individual had applied to register as a manager with CQC.

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We gained feedback from the local authorities, health staff and other professionals who work with the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection.

We used the information the provider sent us in the 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 used all this information to plan our inspection.

During the inspection
We spoke with 24 people who used the service about their experience of the care provided and 10 relatives. We spoke with 24 members of staff including the nominated individual, digital transformation manager, head of care, quality and compliance manager, neighbourhood leads, senior support workers, support workers, kitchen staff, housekeeping staff and members of the maintenance team. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with two people to tell us their experience.

We observed staff interactions with people and observed care and support in communal areas.
We reviewed a range of records. This included eight people's care records and 24 medicines records. We looked at three staff files in relation to recruitment, staff supervision and training. A variety of records relating to the management of the service, including checks and audits, fire safety and maintenance records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance, training records, rotas, COVID-19 testing records and maintenance records.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At the last inspection in July 2021, risk assessments were inconsistent. They did not provide clear guidance to staff about how to meet people's needs safely. Risks of harm had not always been considered. Fire risks had not always been well managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 in relation to risk management.

● At this inspection, some risk assessments had improved. However, risk assessments still contained unclear guidance to staff on how to meet people's needs safely. Some risk assessments conflicted with other information in the care plan and care records (such as choking risks conflicting with nutrition and hydration care plans).
● Risk assessments relating to people living with epilepsy did not include important information about how to support people safely during bath time and other risks associated with epilepsy such as SUDEP. SUDEP (Sudden unexpected death in epilepsy).
● Risk assessments were missing for certain medicines in people's care records. These included medicines such as anticoagulants that may increase the risk of bleeding following a fall.
● Risks of harm had not always been considered. We observed a radiator in a corridor with no radiator cover and was very hot to touch. This posed a burns risk to people if they fell or had a seizure. We reported this to a member of the management team who turned the radiator down to a low setting and logged with the maintenance team that a radiator cover was required.
● We observed hoists being stored in corridors around the service. Despite this being identified in an accident and incident review (when a person tripped over a hoist in the corridor on 04 February 2022) as a hazard. The review of the accident detailed that hoists should not be stored in corridors. We discussed this with the management team during the inspection. They made arrangements to store the hoists elsewhere to prevent further accidents.
● At this inspection fire risks had improved, a person was no longer locked in their apartment with no means of escape. Fire drills had taken place, the last one had taken place on 28 January 2022. However, further work was required, weekly fire alarm tests had not been thorough enough to check each call point was working which meant the provider had not followed the governments fire safety risk assessment guidance for residential care premises. We reported this to the nominated individual who took action to address this during the inspection. Fire drill records had not recorded how long the evacuation took and whether there

was any learning from the drill. Since the last inspection, there had been significant delays in servicing the fire alarm system to meet fire regulations because of an unpaid invoice. This had now been resolved but had caused delays, which may have put people at risk of harm as a number of faults had been detected. Personal emergency evacuation plans (PEEPS) had improved but they still did not contain all the information required to keep people safe. PEEPS did not include information about flammable creams and lotions that people were prescribed.

● Where accidents and incidents had been, the follow up action identified in the management review of these had not always been taken. Such as amending and embedding information to mitigate risks in people's care plans and risk assessments. One person had suffered a burn to their torso from drinking a hot drink. Their hydration support plan had not been reviewed or amended to reflect the risks of burns from hot drinks. Staff had not been given information about not leaving hot drinks with the person unattended. There was no risk assessment in place relating to the risks. The person told us they were still left with hot drinks. Another person told us about an incident that had taken place in December 2021. There were no incident records relating to the incident. We spoke with the management team, who confirmed that an incident had occurred. No records had been made about this and relevant parties such as local authority care managers had not been informed.

The provider has failed to protect people from risks related to fire and the environment. Risks related choking and epilepsy had not been assessed and care had not been planned to keep people safe. Accidents and incidents had not always been responded to and reviewed. This placed people at risk. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection in July 2021, the provider had failed to manage medicines safely which put 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● At this inspection, people usually received their medicines as prescribed. Medicines were administered at set times of the day. However, records showed that sometimes those administering medicines were not following the prescriber's instructions. We could not be assured that people were always receiving their medicines in line with the prescriber's intentions. Internal checks had failed to identify or rectify some of these issues.

● People prescribed 'as and when required' (PRN) medicines did not always have the appropriate protocols in place to support staff to know how or when to administer these medicines. Those people prescribed emergency treatments for epileptic seizures did not always have PRN protocols or up to date seizure management plans in place. We were not assured these medicines would be given appropriately or staff would know when to escalate concerns.

● Where medicine administration charts (MARs) were being amended or hand-written by staff there was often no double check or signature of this to ensure it was correct and in line with the prescribers' intentions.

● Temperature monitoring was taking place daily for medicines rooms and fridges. However, there was no minimum or maximum temperatures being recorded. Also, sometimes the records were being mixed up which made it look like the temperatures were outside of the recommended range in certain areas. This had

not been identified by staff.

These demonstrate a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

At the last inspection in July 2021, the provider had failed to deploy staff sufficiently. Call bells were not always answered quickly. We also observed that call bells were muted or switched off without staff attending to people to find out what they wanted or needed. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. At the last inspection staff were not always recruited safely. Staff recruitment records showed gaps in one member of staff's employment history. These gaps had not been addressed and recorded. This was an area for improvement.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 in relation to deployment of sufficient staff. However, there were areas for improvement that were still required.

● At this inspection, improvements had been made, staff were recruited safely. Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
● At this inspection, improvements had been made. We had not received concerns about lack of staffing. There appeared to be enough staff to meet people's needs. However, we observed one occasion where a call bell had been muted or switched off without staff attending to the person to find out what they wanted or needed. This issue had also been identified at the last inspection. A relative told us, "[Loved on] gets fed up sometimes that the call bell doesn't get answered quickly as reliant on it for toilet." This is an area for improvement. We fed this back to the manager to address.
● Care and support provided to people living in the apartments and bungalows at the service was not always planned in a structured way to meet people's needs. We reviewed the staffing rota for the service including the apartments. The care and support for the apartments was not structured and coordinated in a way which met each person's needs. People who required support with personal care were required to arrange (the day before) a time they would like to get up. If people needed support before this time, they pressed their call bell. The response to people in the apartments pressing their call bell was not always timely. One person gave us their records to show that they frequently were left for hours beyond their agreed time. Their daily records reflected that they had pressed the call bell before the agreed wake up time because of a medical issue and they were denied help until a later time, because there was not two staff available. This is an area for improvement. We fed this back to the manager to address.
● The staffing rota for the apartments did not include structure time for people to have support with preparing and cooking meals. One person told us, "I can cook in my own flat with staff help, but staff are usually busy so not able to help me." We observed this person collecting their meals from the main home each day and taking these back to their apartment, rather than being supported to gain skills and cooking independently. This is an area for improvement.
● At this inspection people and relatives told us staffing had improved. Comments included, "[Call bell response times are] pretty good, they (staff) come quite quickly"; "Staff seem to know their jobs better, there is always someone to listen, they do their best" and "When I need help staff are here for me. Staff are here to talk if I have a problem." A person told us that staff knew them better because staff members were staying in post and not leaving.

Systems and processes to safeguard people from the risk of abuse

At the last inspection in July 2021, the provider had failed to protect service users from abuse and improper treatment. This placed people at risk. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● At this inspection, the culture of the service had improved. There was more of an open and honest culture where staff were empowered to raise any safeguarding concerns. Staff told us they felt comfortable to report concerns to the provider and management team. They felt that concerns were taken seriously and appropriate action was taken.
● The management team had appropriately raised safeguarding concerns, prior to this inspection and did so during the inspection, when a person returned from hospital with signs that they had not been cared for correctly during their hospital stay.
● Most people told us they felt safe living at the service. Relatives also told us their loved ones were safe. Comments included, "I feel safe now. Staff use hoist and they talk to me about it" and "He (loved one) is safe and we do not have to worry about him when we leave."

Preventing and controlling infection

At the last inspection in July 2021, the provider had failed to test staff and people for COVID-19 and were not following government guidance on testing in care homes. The provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the service were dirty and had not been cleaned effectively. We were not assured that the provider's infection prevention and control policy was up to date. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to preventing and controlling infection.

● At this inspection, improvements had been made. 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. One person told us, "It is kept clean, cleaners come around morning and evening, wiping surfaces. Yesterday they did the carpet."
● 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.

The provider had a system in place to enable people to have visitors. Visitors were temperature checked on arrival, undertook a lateral flow COVID-19 test and were asked to wear masks to keep them and people safe.

We observed this system working and people received visits from their relatives during the inspection.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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

At the last inspection in July 2021, people's care plans contained conflicting and confusing information about their mental capacity. Mental capacity assessments had been made for each decision. It was not always clear when a person lacked capacity, and when a best interest's decision had been made, who had been involved in the decision-making process. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- At this inspection, no improvements had been made. People's care plans contained conflicting and confusing information about their mental capacity. Mental capacity assessments had been undertaken; however, they were not always clear about what the decision being assessed was. It continued not to be clear when a person lacked capacity, and when a best interest's decision had been made, who had been involved in the decision-making process.
- There was no management oversight of DoLS to monitor when DoLS were due to expire, when DoLS applications were required and what conditions were in place for people that had conditions on their DoLS.
- Where people had a DoLS authorisation, this was not detailed in their care plans. This meant staff did not

have the information they needed to understand people's legal status and make sure their rights were upheld. Staff were unable to seek advice from the management team in relation to DoLS because the management team were unaware of who had DoLS authorisation and conditions in place.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection in July 2021, the provider had failed to ensure staff had the appropriate training to ensure people's needs were met. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At this inspection, it was clear a programme of training was underway. Some staff had received training relevant to meeting people's assessed needs. However, there continued to be staff missing from the training matrix. We identified four staff missing from the matrix when we matched the records with provider reports that had been submitted prior to the inspection. At the last inspection we reported that de-choker training was not included on the training list, but people's choking risk assessments stated staff were trained. At this inspection, training records showed that 51 out of 68 staff had completed eLearning training on this.
● At the last inspection, we raised concerns about the content and structure of epilepsy and administration of emergency medicine (for treating epilepsy) training. At this inspection, more staff had completed the training. However, concerns raised by health professionals prior to the inspection evidenced that some staff were not always aware that people were experiencing a seizure. This led to health professionals intervening to make sure people were safe. We discussed this with the nominated individual who agreed that additional training around epilepsy was required. They explained epilepsy was covered within a first aid course that staff attended, and they felt that this was not sufficient enough to give staff all the required information and training they required to safely support people who lived with epilepsy.
● Catheter care training had been completed by 26 staff out of 71. One member of night staff out of 10 night staff had attended catheter training despite supporting people with catheter care needs. This put people at risk of harm.

The failure to ensure staff had the appropriate training to ensure people's needs were met is a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Fifteen staff had completed Makaton training to help support them to communicate effectively with people who used Makaton signs to communicate.
● Most staff felt well supported by the management team. Records showed that staff had received regular supervision meetings with their supervisor and a process was in place to ensure staff received an annual appraisal. Staff told us, "[Nominated individual] is great, massively supportive, she knows what she is doing"; "[Nominated individual] has been massively supportive, has been a real bonus to the service. She is really supportive of staff but knows what things should be like and is clear about this"; "[Nominated individual] has been massively supportive and is an inspiration to us, as she has a lot of knowledge and knows what she wants" and "I feel [nominated individual] is supportive, she has made a difference. The management team

are more supporting for staff."

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

At the last inspection in July 2021, people's assessments had not been reviewed and updated when their needs changed. For example, when people's mobility had changed which meant they spent prolonged periods of time in bed or their wheelchair, skin integrity risks had not been reviewed and updated. This meant people may be at risk of pressure damage to their skin. People and their relatives did not always feel fully involved and kept up to date with assessment processes. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At this inspection, no new people had moved to the service since the last inspection. People who had been discharged from hospital back to the service had their needs reassessed. These assessments were used to develop and review the person's care plans.
● Assessments included information about the care and support people needed with their nail care. However, the care and support identified in the assessment had not always been added to people's care plans. We observed a number of people with long fingernails, some people had hands that were contracted due to their physical health needs. One person was observed to have a red sore in the palm of their hand because their fingernails were long and digging in. Their care plan did not list the support they required from staff to maintain their nails and staff were unaware that the person had long nails or a sore.
● The assessments and re assessments of people's needs had not led to goals and action plans being set to support people with learning disabilities to develop and improve their skills and maintain certain levels of independence, this meant there were no clear pathways to future goals and aspirations, including skills teaching in people's support plans. People had not always been reassessed in a timely manner when their needs changed. One person had been prescribed emergency medicines to treat seizures. Their medication assessment did not detail the new medicine and reasons for this.

The failure to provide care and treatment to meet people's assessed needs is a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

At the last inspection in July 2021, people told us that the meals were of poor quality and lacked vegetables and were not balanced. Food and drink did not always meet people's assessed needs. Fridges in communal kitchen areas were dirty and contained food that had not been appropriately labelled after it had been opened. The provider had failed to meet people's nutritional and hydration needs. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

● At this inspection, people gave us better reviews of the food. No one told us that food lacked vegetables and was not balanced. However, we did receive mixed feedback. Two people and two relatives said the meals were too big which put some people off eating them. One relative raised concerns that their loved one had put on a considerable amount of weight which they were concerned about. We checked the person's

weight records which confirmed this. We raised this with the management team. After the inspection the service introduced different sized portions to the choices available for people. One person told us, "The food was good but said sometimes I do not get a choice and I do not always like the one dish that was on offer."
● Fridges and cupboards in communal areas continued to contain unlabelled foods and some were not clean. We reported this to the management team who took action to address this.
● We observed that supper was served to everyone on paper plates, this made it difficult for people especially with hot and sloppy meals such as beans. Staff confirmed that the supper/teatime meal was always served in this way. One person told us, "It is my biggest bugbear being given food on paper plates." We discussed this with the management team. After the inspection we received confirmation that people's supper was no longer served on paper plates.
● Mealtimes were relaxed and people were supported to have meals and drinks that met their needs. Most people living in the apartments received their meals from the main kitchen.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At the last inspection in July 2021, people had not always had access to medical appointments in order for their health needs to be met. Healthcare professionals fed back that many appointments had been cancelled or missed because of a lack of availability of drivers to support people to appointments. The provider had failed to provide care and treatment to meet people's assessed needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9 in relation to meeting people's health needs.

● At this inspection, most people had access to health services when they needed it. However, outcomes of appointments (for people who required support to attend) and details of concerns were not always recorded and clear.
● At this inspection, people had been supported with accessing physiotherapy, occupational therapy, GP and healthcare specialists when required. Records evidenced that staff had called 999 and 111 when required to meet emergency medical needs. Relatives told us, "They get the doctor for her when needed. She was seen by the district nurse a few weeks ago"; "They are very quick to call a doctor or paramedics. He is booked in to see the [specialist] nurse and SALT (speech and language team). The floor Manager goes with him to hospital when able. Staff keep me well informed with what's happening."
● One person who lived in the apartments at the service continued to experience issues with booking and attending medical appointments because of lack of drivers at the service. They told us they required support from staff to travel in the community. As a result of the lack of drivers they had independently travelled to their GP and pharmacy and attended these appointments without support. They told us, "I am not ok to do this."
● Before the inspection, healthcare professionals shared that one person had clear and specific physiotherapy plans in place which required the staff to support with exercises. Healthcare professionals had provided training and guidance to staff to enable them to support people effectively and improve the person's mobility and movement. Healthcare professionals shared that despite this being in place, each time they revisited people the exercises had not been taking place and the person's mobility had deteriorated as a result. This had now improved and the person had been supported to walk regularly. We observed them walking during the inspection.
● Before the inspection, healthcare professionals shared concerns about epilepsy management, monitoring and recording. During the inspection we found that there were inconsistencies in relation to management of

epilepsy and recording issues. One person's seizure records were not complete. Another person's care records contained no seizure management information for staff to follow should the person have a seizure and there was no protocol in place in relation to emergency medicines.

Although some improvements had been made, further improvements were required to ensure each person received care and treatment to meet their assessed needs. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

At the last inspection in July 2021, the provider had failed to ensure the premises is suitable for the purpose it is being used this is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Maintenance tasks had not always taken place in a timely manner, which could put people at risk of harm. Contractors who had serviced the beds had identified several repairs that were required, these had not been signed off as actioned. The service was not clean. There was no dementia friendly signage in place and way marking around the service, despite some people living with dementia.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● At this inspection, maintenance tasks were observed to be completed in a timelier manner. A redecoration programme was in place and some rooms were already complete. People's rooms had been decorated and furnished to their own tastes. People told us they had been involved in choosing the colours. One person said, "I am back in my room today after decorating. The colour is lavender."
● At this inspection we observed a large amount of furniture in people's bedrooms were damaged exposing bare chipboard which also created an infection control risk as well as rough surfaces which could cause skin tears. This damage had not been identified by audits and checks and management walk rounds of the service. We reported the concerns to the management team in the daily meeting. The nominated individual advised the management team to assess each person's room to address any damage to furniture as a result and confirmed that broken and damaged furniture would be replaced. The provider told us they planned to replace all furniture in the service at the end of year once the redecoration was complete. Several relatives had noticed the damaged furniture and commented about this. One relative said, "Maybe some of the furniture could be replaced, looks tired. Her room is okay."
● It is evident that people know their way around the service and were seen actively finding their way to lounges, dining rooms and their bedrooms as well as outside. However, there was no dementia friendly signage in place and way marking around the service, despite some people living with dementia. We observed one person living with dementia frequently walking into other people's bedrooms. This is an area for improvement.
● At this inspection, the service was cleaner; spillages were cleaned up quickly. Bathroom, toilets and ensuite floors were cleaner. We did not detect any unpleasant odours at this inspection.

Requires Improvement

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 requires improvement. At this inspection the rating has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

At the last inspection in July 2021, people were not consistently receiving good care. People were not always treated with dignity and respect. People's personal records were not always stored securely to ensure they were only accessible to those authorised to view them. People's cultural needs were not always respected. Some people were not always supported to maintain important relationships with people when they could. During the COVID-19 pandemic people have relied on video calling and telephones to maintain contact with their loved ones. Not everyone living at the Little Oyster Residential Home had been enabled to do this because of poor WIFI signals in certain areas of the service. This was a breach of Regulation 10 (Dignity and respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

● At this inspection, most people told us they were receiving better care and support. People told us, "All very good. [Staff name] she's very nice"; "If I say I need a bit of help they help. I ask for a bath and hair wash when I want, twice a week. I can have more if I want"; "All the staff are good and very happy" and "We have our independence and also our privacy." However, this was not everyone's experience, one person residing outside of the main building told us their care and support had got worse since we last inspected. They gave us examples of incidents and issues that had occurred which made them feel they were not treated with dignity or respect by any of the staff team. We raised these concerns with the local safeguarding authority.
● At this inspection, people's care records were securely stored to prevent unauthorised access. Records held on computers were only accessible to those with passwords. Despite this, private and confidential data was not always kept secure. Confidential information about people who lived at the service had been given to ex staff members (including a manager).These ex staff members did not have the legal right to the information. Where ex staff members had permission to have telephone numbers for people when they worked at the service, they had not removed telephone numbers after leaving. One person told us, "I have not replied [to a message received from an ex staff member]. I did not give them permission to keep my number and contact me, it is a violation of my information and I do not know who has told them information about me, which makes me not trust anyone."
● We observed some nice interactions between staff and people, which showed that some staff knew

people well, knew how to communicate with them and helped inspectors communicate with people. However, one person's care plan showed they communicated using pictures. We asked staff about this, the cards were not located with the person or in their room and some staff did not know where they were. This meant staff could not communicate effectively with the person. The person's picture cards were located on the second day of the inspection.

● People's needs were not always respected. Two people told us they did not receive support with their personal care in line with their wishes.

● One person told us they did not feel safe, they provided examples of how they had been treated differently to others. This made them upset and they felt disadvantaged. We informed the local authority safeguarding team who started investigations.

● Some people had a preference not to receive care and support from people much younger than them. One person told us, "The biggest problem is very young staff, I don't like 17/18-year olds doing my care. They think they know everything when they don't." This person became quite upset about this. A relative told us, "the manager has said to me today that they plan to recruit older staff to restore some balance and I support that. For a long time there have been very young and inexperienced staff at the service."

● At this inspection, although improvements had been made in the service, these were not fully embedded or consistent across the service. This meant people were not consistently receiving good care.

The failure to treat people with dignity and respect is a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection, WIFI connectivity throughout the service had been improved. People who were isolated previously, now had more opportunity to connect with friends and loved ones. One person (who had previously had limited opportunity to engage with friends and family in their bedroom) now had a smart speaker to support their mental health and wellbeing.

● Most people told us their views and wishes were listened to. People told us they had provided feedback to the management team and they had been listened to, action had been taken to improve things. However, one person had asked to move rooms. This had not been acted on, despite suitable rooms being available. We fed this back to the management team who told us the person's wishes would be met as there was a vacant room in the part of the building they wished to move to. We observed the nominated individual and other members of the management team met with people as part of a 'Resident's meeting' on one of the days of inspection. Minutes were taken and actions recorded to make sure voices were heard.

● Some people had moved bedrooms and areas in the service. People who had moved told us they were very happy. Their belongings had been moved with them.

● Staff were discreet when asking people if they needed to use the toilet. Staff ensured any support with personal care was carried out behind closed doors. We observed staff checking with people that they were warm enough and brought blankets to help those that said they were cold.

● Most people and relatives told us the staff were nice and kind. Comments included, "Most of the staff very good though and I love them"; "Happy with staff"; "It is a good place to live"; "Staff are kind" and "Staff are very friendly."

Requires Improvement

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 requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At the last inspection in July 2021, care and support plans were not always person centred and were inconsistent. The failure to design care and treatment to ensure people's preferences and needs are met was a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At this inspection, whilst care plans were improving there were still improvements to make. Some care plans were not clear and some conflicted with other information about the person. For example, one person's choking care plan conflicted with their SaLT assessment. This meant the person was at increased risk of choking if staff read the care plan in isolation. Some care plans referred to people as the different gender or contained other people's names. This evidenced that the care plan was not person centred to the individual.
● Some people told us their personal care needs were not always met as they would like. We checked personal care records and it was not always clear what personal care had been provided, this included oral care. For example, one person told us they would like their teeth to be brushed twice a day. Staff only did this once a day. Their care plan did not specify their wishes to have their teeth brushed twice a day. The person told us that they wanted to have a shower every day. They said, "I can't remember the last time I had one, it's rarely once a week." Their care plan did not make it clear that the person wanted to be offered a shower each day.
● At the last inspection, people had very long fingernails which they had not been supported to clean and maintain. At this inspection, people continued to have long nails and received a lack of support maintaining these. Some people's care plans did not mention the support they needed with their nail care at all. This meant staff did not have all the information they needed to provide person centred care.

The failure to design care and treatment to ensure people's preferences and needs are met was a continued breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● At the last inspection people's nails were visibly dirty. At this inspection we observed that people's nails looked clean.

Improving care quality in response to complaints or concerns

At the last inspection in July 2021, the provider had not followed their complaints processes when responding to complaints received. The failure to acknowledge, investigate and take action in response to complaints was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 16.

● At this inspection, the provider had not followed their complaints processes when responding to complaints received. There had been five complaints received about the service since the last inspection. There was no evidence these had been dealt with in line with the provider's policy and no evidence these had been resolved. We spoke with the nominate individual about this. They told us the service was at fault for not following the processes and policy.

The failure to acknowledge, investigate and take action in response to complaints was a continued breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● People and their relatives told us they would complain to the staff or the management team if they were unhappy about their care. People knew who the manager was and how to complain. Relatives knew who the manager was and felt confident with raising issues and concerns with them.
● Comments included, "I speak to the manager when I want"; "They (manager) would give me time and take me seriously" and "I would speak to a carer, the floor manager then the actual manager. They are always happy to talk to me."

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

At the last inspection in July 2021, there were no opportunities for meaningful occupation taking place in the service during the inspection, people told us that activities did not take place. The failure to ensure people's individual needs and preferences were met is a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9 in relation to meaningful occupation and avoiding social isolation. However, there was some further improvement required.

● At this inspection, activities had improved for some people. We observed activities taking place which included; music and movement and baking. Some people were supported to attend these sessions and other people who were able to mobilise independently had taken themselves to the room where activities were held. However, some people told us they were still bored. They said they wanted to participate in activities and spend time out of their beds. One person said, "I am bored stiff, I would get out of bed to join activities, but no one asks." This evidenced inconsistency across the service. This is an area for improvement.
● Other comments from people and relatives included, "Activities are better"; "[Person] is not over keen on activities, [person] likes it with music man, [person] did tell us today that they did not do the exercise class

as we were here today. We have noticed now things have improved a lot, there seems to be more activities available and the atmosphere seems more buzzing and jolly"; "I think they did really well during COVID. They did Bingo along the corridor and would always tell us what she did. She likes making pom poms, ceramics and painting in her room. Staff will help her"; "I have got to know other people and sit and talk to those that can"; "Today we are making Carnival hats"; "I like going out. I do not go out every day. I would like to go out every day"; "I would like to do DIY"

● The activity coordinator showed us photographs of recent activities and events which included, bowls, arts and crafts, baking and Jabadao (this is an activity using a large piece of material that looks like a parachute which encourages movement and interaction). Some people told us they went out of the service independently to access their local community; others were supported to go out with relatives. Activities were planned in advance, during the inspection the activity schedule for March 2022 was put on display.

● Staff told us, "Activities have improved, [activities coordinator] has got so involved with activities, she encourages people to get involved. If they decline she does 1:1. For example, she sits with [person] and reads to him" and "I think people have a good life as they get regular walks on the beach and there are activities going on."

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.

● Most people's communication needs were known and understood by staff. People's support plans included details which helped new and unfamiliar staff learn about how people expressed their needs.

● Information was shared with people and where relevant, available to people in formats which met their communication needs. There were some visual aids around the service, for example informing people about complaints, staying safe from abuse, COVID-19 safety, social distancing guidance, menu's and activities.

● One person's support plan had been translated into their native language.

● People were supported by assistive technology and smart speakers to engage with others and communicate.

End of life care and support

● The service was not supporting anyone at the end of their life at the time of the inspection.

● The management team understood that if people's health deteriorated, they would seek advice and guidance from healthcare professionals to ensure people had the right care and support at the end of their lives.

● Some discussions had taken place with relatives to look at end of life wishes. Some people had a DNACPR (do not attempt resuscitation) in place which had been discussed and agreed with their relatives and consultants.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

At the last inspection in July 2021, the systems in place to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. Timely action had not been taken to address issues identified from audits. People were at risk because the provider had not acted to ensure they had enough oversight of the service. Records were an area of concern across the service. Archived records were held outside of the service. We were not assured that the records retained in the container were stored, monitored and disposed of following data protection legislation. The was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● At this inspection, audits and checks had been taking place which were completed mostly by the management team. Some audits and checks had not picked up on some of the issues identified in the inspection. For example, the audits had not identified that actions arising from accident and incidents had not been completed. Audits had not always picked up concerns in relation to records. Management walk round checks were completed twice a day, these checks had not identified concerns in relation to health and safety risks such as hoist storage, burns risks from unguarded radiators and damage to bedroom furniture.
● Records remained an area of concern across the service. Records were of poor quality, were inconsistent and did not include a complete, accurate and contemporaneous record of care provided. People's food and fluid records were not always completed to evidence that they had received suitable nutrition and hydration to keep them healthy. One person's fluid records did not always record the amount of fluid given. They were at risk of malnutrition and dehydration and their food and fluid should have been recorded. Their meal records did not always record what was offered or eaten. One meal was recorded as 'soft option 40% consumed.' Shower and bath temperature records were not adequate. Two people's records showed that the temperature of the water had been recorded as 'warm' this indicated that staff had not used thermometers to check the actual temperature of the water to make sure it was safe for people to use.
● Records were submitted to CQC weekly as part of the conditions imposed on the provider's registration after the last inspection. Accuracy checks were not always completed and submissions had often contained errors and misinformation.
● At this inspection, some lead roles have been developed to drive improvement in the service. These had not been fully developed and embedded. Some staff in these roles required training, coaching and support to understand what the lead role entailed, what outcomes people living at the service could expect and how

they can support people in relation to these.

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Archived records kept off site were being reviewed and systems had been put in place to make sure records were stored, monitored and disposed of following data protection legislation.
● At the last inspection, the provider had not acted to ensure they had enough oversight of the service. At this inspection, the provider was able to demonstrate they had a better oversight of the service. They liaised frequently with the nominated individual who was managing the service and had a better understanding of what was happening. The provider was committed to making improvements, "making things right" and investing in the service to ensure people had a safe, comfortable life.
● People and relatives knew who the manager was and told us improvements had been made. Comments included, "I know I can talk to the staff or manager anytime. The floor Manager deals with [person] first-hand. She really likes her and so do I"; "Staff respond to issues arising"; "On the whole I'm happy but with a few niggles"; "We feel reassured by visiting"; "I can't think of anything I'd want changed or improved. I cannot fault them"; "I can see an improvement in the last three months. He is happy and content" and "I think the front room could be cosier. I suggested some plants to the manager and she is going to sort it out". Two people told us they would rate the service "12 out of 10. It meets more than my expectations" and "11 out of 10."
● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider had notified CQC about important events such as deaths, serious injuries and safeguarding concerns that had occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● At the last inspection, the provider had not acted to develop a culture of respect and inclusion for everyone. Whistle blowers told us that there was a poor culture within the service and a lack of support. At this inspection, the culture had improved. Staff told us they felt well supported and knew how to raise concerns with the management team. They felt listened to. Staff provided in general positive feedback about the support from their managers (from neighbourhood leads to the manager). Those spoken with felt communication was improved and guidance was available when needed. We did receive some whistle blowing during the inspection which conflicted this but were unable to find evidence to corroborate this.
● There was more structure to the management of the service, a daily meeting took place with the manager and staff from each area of the service, this included maintenance, kitchen, housekeeping, activities, administration and care. This enabled better information sharing, staff were involved in developing appropriate actions to problems that cropped up.
● Since the last inspection the manager had introduced a 'resident of the day' system. This meant that when a person was the 'resident of the day' they had their care plan reviewed, bedroom deep cleaned, they were able to choose a meal outside of the meals on offer on the menu. They also undertook activities which were important to them. During the inspection it was clear this was happening for people. We observed one person had their hair dyed and they took part in activities they wanted, other people went out shopping and spent time having a meal out.

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

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their rating in the main entrance to the service and on their website.

● The manager understood their responsibilities to ensure compliance in relation to duty of candour. Duty of candour is a set of specific legal requirements that service providers must follow when things go wrong with care and treatment. It was evident that the manager had communicated with relatives following the last inspection in relation to the rating of the service and what action was taking place to address the findings.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection in July 2021, the provider had failed to act on feedback from people, staff and their relatives to continually evaluate and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17 in relation to acting on feedback from people, staff and relatives. However, there was a further area of improvement to be made.

● At this inspection, most people were listened to. Most people told us the management team had listened to them when they had made suggestions and requested improvements.

● The service had received five compliments since the last inspection from people and relatives. One was from a relative of a person who had passed away in 2021 thanking the service and staff for all they did for their loved one. Another was from a relative thanking the service for enabling them to visit and have Christmas dinner at the service with their loved one. They said, the meal was superb, staff were welcoming and there was a great atmosphere.

● Relatives meetings and staff meetings had taken place to gather feedback, share information and discuss improvements planned.

Working in partnership with others

● The service worked in partnership with people, their relatives and health and social care professionals to ensure people had the best outcomes.

● The management team had taken the opportunity to attend video link local forums and national events to liaise with others and keep up to date with good practice. This included local infection prevention and control provider and manager networks, which they had found useful.

● The management team maintained contact with local authority commissioners, quality assurance teams and staff as well as health care professionals such as GP's, district nurses and consultants.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider has failed to acknowledge, investigate and take action in response to complaints. Regulation 16 (1)(2)

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 9 HSCA RA Regulations 2014 Person-centred care The provider has failed to design care and treatment to ensure people's preferences and needs are met and failed to ensure each person received care and treatment to meet their assessed needs. Regulation 9 (1)(2)

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider has failed to treat people with dignity and respect. Regulation 10 (1)(2)

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider has failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005. Regulation 11(1)

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment The provider has failed to protect people from risks related to fire and the environment. Risks related choking and epilepsy had not been assessed and care had not been planned to keep people safe. Accidents and incidents had not always been responded to and reviewed to. The provider has also failed to manage medicines safely. Regulation 12 (1)(2)

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. Regulation 17 (1)(2)

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to ensure staff had the appropriate training to ensure people's needs were met. Regulation 18 (1)(2)

The enforcement action we took:

We imposed a condition on the providers registration