Dimensions Somerset Sev Limited

Dimensions Somerset Yeovil Domiciliary Care Office

Inspection report

Houndstone Close
Yeovil
BA21 3RL

Date of inspection visit:
24 February 2021
01 March 2021
03 March 2021
09 March 2021

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17 June 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Dimensions Somerset Yeovil Domiciliary Care Office is a domiciliary care agency providing personal care to 63 people with learning disabilities and/or autism in their own homes or flats in the community. Most people had limited verbal communication so unable to feedback their views. Other ways of collecting their views were used such as observations during visits and speaking with those important to them.

People lived in one of the nine supported living services, shared accommodation or individual homes and flats. Many of the households had multiple occupancy of over three people with shared living spaces. Most people required 24-hour support, and this changed for some during the COVID-19 pandemic.

People's experience of using this service and what we found
The service was not well led. Systems failed to ensure that the quality and safety of the service was effectively monitored. A reactive approach was found that relied on external agencies such as the local authority, clinical commissioning group and Care Quality Commission (CQC). The provider's quality assurance action plans contained generic, copied phrases that lacked detail. There were shortfalls found during the inspection which had not been identified by the provider's internal monitoring systems. Multiple breaches of regulations were found. We also made a recommendation about the retention of staff.

People were comfortable in staff presence and told us they were safe. Most relatives thought their family members were safe. However, people were placed at risk of potential harm, for example the risks from choking or skin damage had not been safely managed. Systems were not always working to protect people from abuse including the use of restrictive practices when a person's arm was prevented from moving during a blood test.

Medicines were not always administered in line with the provider's policies and current best practice. Systems to prevent the spread of infections during the COVID-19 pandemic were not being consistently followed. Not all staff knew how to safely remove and dispose of personal protective equipment (PPE) such as gloves, masks and aprons.

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.

This provider was not able to demonstrate how the service was meeting some of the underpinning principles of 'Right support, right care, right culture.' A high staff turnover increased the risk that people's personalised health and care needs would not be met. Risks of inappropriate restrictions placed on people from staff new to care was found to be impacting on people's rights. We identified a reactive rather than

proactive management approach across the service to deliver personalised care to people.

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 18 April 2018)

Why we inspected
We received concerns in relation to about the provider including potential closed cultures, staffing and safe care and treatment. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well led sections.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, keeping people safe from abuse and systems to manage the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Dimensions Somerset Yeovil Domiciliary Care Office

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector and a medicines inspector. One inspector completed on site visits. Another inspector completed virtual visits using video calls. The assistant inspector made phone calls to relatives. Additionally, two Expert by Experiences made phone calls to relatives. 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 is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

This service also provides care and support to people living in nine '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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was supported by locality managers who ran either one or multiple supported living homes/services. Each home also had a better practice lead to support best practice being delivered to

people.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a complex service and we needed to arrange visits to people's homes during a COVID-19 pandemic.

Inspection activity started on 24 February 2021 and ended on 12 March 2021. We visited the supported living settings on 24 February 2021, 1 March 2021, 3 March 2021 and 9 March 2021. Virtual visits started on 2 and 9 March 2021. Throughout the inspection other phone calls and virtual calls were had with the registered manager.

What we did before the inspection
We reviewed information we had received about the service since the last information. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people at the inspections and 26 staff members of various levels from the registered manager, locality managers, better practice leads, support workers and agency staff. Twenty-five relatives were spoken with on the telephone. Nine health and social care professionals shared their views and there was a virtual meeting with five health professionals. We reviewed a range of records including medicine records, 29 care plans, five recruitment records and a variety of records relating to the management of the service including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We continued to look at records relating to people's care, quality assurance records, training records and policies and procedures.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Systems and processes to safeguard people from the risk of abuse

- One health and social care professional raised concerns around staff lack of understanding of restrictive practices. We found people were at risk of being inappropriately restrained. One person was found to have been restrained inappropriately on the day of inspection during a blood test by a staff member preventing their arm being moved. Staff told us this was not the first time they were restrained during a blood test. Action was taken immediately by the locality manager to reduce the risks of this happening again.
- People were at risk of abuse because systems had not always identified concerns which should have been raised under safeguarding protocols. For example, when there was unexplained bruising to people reported. Health and social care professionals provided us with other examples, such as the provider's locality managers not immediately reporting safeguarding incidents and staff member's inappropriate use of restrictive practices.
- Historical or repetitive concerns had not been addressed promptly. For example, one incident record stated the same circumstances had been happening for two years placing people and their property at risk. Plans were now in place to resolve it prevent this happening. Again, this issue of repetitive concerns had been an ongoing issue for some health and social care professionals. Following the inspection, the provider told us they had been raising the concern with the housing association regularly and it was out of their control.
- Four incident records stated external bodies, such as the local authority and the Care Quality Commission (CQC), had been informed due to safeguarding issues being identified during each incident. No records of any of these incident reports could be found by CQC.
- People were supported by staff who knew how to raise concerns within the organisation. Most staff felt their concerns would be listened to although staff told us that some locality managers had not taken their concerns seriously. For example, a staff member told us they had they had witnessed poor support and previous locality manager did nothing. Following the inspection, the provider told us when they recognised there was an issue with this locality manager they removed them from working in the service. There were occasions when staff were unsure who to contact externally with concerns so, if their concern was not resolved internally, they did not know who to contact.
- Since the last inspection, there had been a significant safeguarding issue affecting people living in one of the supported living properties leading to 13 of 16 safeguarding concerns being upheld. Improvements have been made by the provider since concerns were first raised.

Systems were either not in place or robust enough to identify that risks of abuse to people had been identified and effectively managed. This placed people at risk of abuse. This was a breach of regulation 13 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us they had taken actions to improve or action some of the concerns we identified. They also explained that prior to the inspection any locality manager found not reporting concerns as they should have was removed from working in the service.
● People appeared comfortable in the presence of staff. Positive interactions were seen in all services we visited. People smiled, gave thumbs up or said "Yes" and "Yeah" when they were asked if they felt safe.
● Most relatives felt their family members were safe. Comments included, "I feel he is certainly safe there and have no concerns", "I think my relative is safe" and, "From what I can gather my relative is safe." Another relative listed some concerns they had, which we checked the provider had followed up.

Assessing risk, safety monitoring and management
● Not all risks to people had been identified or safely managed. People were not always being kept safe from the risks of choking or aspiration when eating and drinking. One person's food was not thickened as recommended by the speech and language team, which meant they were at risk of choking. Neither of the staff members preparing the food or assisting the person recognised this. Another person was seen coughing during the inspection and had not been reassessed as required. Following the inspection, we were informed a speech and language therapist had reviewed this person's eating and drinking needs and their care plan to ensure the person's safety.
● One person required a specific way of being administered their medicine and food supplements. Whilst some staff had their competency to do this checked by visiting health professionals' in line with the provider's policy, this was inconsistent, and some staff had not completed full training. This meant there was a risk staff were not completing the task safely.
● People were placed at risk of harm because on occasions decisions were made not considering each individual's specific health and care needs. For example, individual risks to some people's health had not been fully considered. People had access to unhealthy snacks even if they lacked capacity to make decisions around the dangers of eating too much or if this would have an adverse effect on their health.
● People were placed at risk of harm in relation to skin care. Those at high risk of pressure ulcers forming due to their health conditions had limited or no guidance in place to keep them safe. One person was reported to have had skin redness which could indicate pressure damage. This person had no guidance or risk assessments in place about risks to their skin integrity. Staff supporting them had a mixed understanding of skin care. Following the inspection, the locality manager confirmed action had been taken including contact with the person's GP to put plans in place to keep the person safe from skin damage.
● Staff lacked knowledge to keep people safe when specialist equipment malfunctioned, such as air mattresses and cushions that were in place to reduce the risks of pressure ulcers. Following the inspection, we learnt contact was made with health professionals by the locality manager to ensure adequate guidance was in place for staff to follow.
● People were placed at risk of inconsistent or poor care. Shortfalls were found in care plans because there was a lack of detail to provide guidance for staff. For example, if people started to age guidance had not been provided to staff about age related changes. One person lacked any guidance or information about communication systems they used to use. Health and social care professionals had also raised similar concerns with us.
● Management and the staff had not always recognised environmental risks to people in shared houses to reduce the risks of harm when people had mixed capacity and were aging. For example, in two of the shared houses radiators did not have covers and could be a scalding risk.

Systems were either not in place or robust enough to identify and reduce risks to people. This 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.

Staffing and recruitment

● There were enough staff available. However, there was a high staff turnover, and this had impacted on the standards and consistency of care afforded to people.

● Relatives were concerned with the high turnover of staff and use of agency staff. Comments included, "They keep changing the managers…so many have left. There is a big staff turnover", "The staff are changing all the time. It is not running as smoothly as it used to" and, "The turnover of staff is appalling. Sometimes my relative sees a staff member once and then they go. This is like bereavement for my relative."

● Staff raised concerns that there had not always been a stable staff team. At times they felt this could place people at risk of harm, especially during the COVID-19 pandemic due to inconsistent care. Additionally, staff members told us they were tired as they covered most of the vacant hours themselves. This may place people at risk of harm due to mistakes being made.

● During visits we found people were supported by enough staff. However, there was use of agency staff including one who worked across two of the shared houses during the COVID-19 pandemic on a very long shift. One of them was meant to be considered 'in isolation' because of a recent COVID-19 outbreak. By moving between the two shared houses, the agency staff member was at risk of potentially spreading the COVID-19 infection.

● People were placed at risk of potential harm and not having their needs met because turnover of staff was high. Many staff members we met, including locality managers, had not been supporting the same people for long. Impacts of this were found because important information was being lost or forgotten. For example, communication systems were not being used effectively and known risks to people were not being managed.

● Health and social care professionals raised concerns about the turnover of staff leading to issues obtaining key information. Comments included, "Across the board one of the things we have noticed has been a lack of consistency of staff, particularly managers and deputies" and, "Turnover at most of the services I have had any dealings with appears to have been very high, including front line managers."

● Agency staff were used when there were shortfalls in staff. Occasions were found when agency staff made errors which could potentially place people at harm. Following the inspection, the provider informed us the use of agency had increased during the COVID-19 pandemic due to the exceptional circumstances they faced.

● The provider's own systems showed three of the shared houses had more staff vacancies in March 2021 compared to April 2020. Their analysis also showed that six of the shared houses still had staff vacancies. This meant staff recruitment and consistency of staffing remained an issue.

We recommend that the provider finds reputable sources on retention of staff to prevent high turnovers so people have consistent, high quality care.

● Following the inspection, the provider informed us of plans to reduce the staff turnover including plans around recruitment and improved retention of staff.

● People were supported by staff who had been through a thorough recruitment process. This included checks with previous employers to confirm their suitability in working with vulnerable people

Using medicines safely

● The quality and safety of medicines management varied across the service. Some issues found placed people at risk of inconsistency of administration and potential harm.

● People receiving 'as required' medicines did not always have the required guidance in place to ensure consistency of administration. One person had recently been prescribed two medicines and there was a lack of guidance for staff which increased the risk of medicine errors. Other guidance found was generic and lacked detail or was in place for medicine now administered routinely rather than as required.

● One person had recently had antibiotics prescribed. These had not been evenly administered throughout the day to ensure maximum efficacy.
● Handwritten entries to medication administration records were not completed in line with the provider's policies or best practice. Additionally, the paperwork relating to the changes were not always stored with the amended records. This meant staff administering the medicine would not be able to check the amendments were in line with the prescribers instructions.
● People who lacked capacity and had medicines administered hidden in food were at risk of not having their best interest being considered.
● People who have their medicine taken mixed with food had no written records of checks with the prescriber and pharmacy to ensure it was safe to administer with food and not impact the efficacy.
● Some staff competency checks lacked detail leading to inconsistent staff understanding in safely administering and managing medicines. On one occasion a staff member was found to make an error for something they had been assessed as competent for.

We found no evidence that people had been harmed. However, systems were either not in place, consistently used or robust enough to safely manage medicine. This 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.

● Following the inspection, the provider confirmed actions they had taken to rectify concerns identified during the inspection. This included embedding a medicine administration system which was being transferred to.
● Detailed plans were in place for most people to highlight their preferred methods of administration. Staff appeared familiar with these. One person told us staff "Help [them] take their tablets."
● Medicines were stored in a safe and personalised way. Temperatures of medicines being stored were regularly being taken to ensure it was within the safe range.

Preventing and controlling infection
● People were placed at risk of infections being spread during a COVID-19 pandemic. Staff were wearing personal protective equipment (PPE), such as masks, aprons and gloves. However, staff were unaware how to safely remove the PPE in the correct order to reduce the risks of infection spreading.
● Systems were not always in place to safely dispose of PPE once it was used. Staff told us how they would walk from potentially contaminated areas to clean areas in some supported living properties with used and unbagged PPE. Again, this increased the risk of infections spreading.
● Fans had been used in shared houses during the COVID-19 pandemic without considering the risks or following the latest government guidance to infections being spread.
● Systems were in place at provider level to ensure current government guidance was circulated as it changed. However, the registered manager had not set up systems to monitor this was being correctly followed across the service. For example, competency checks to ensure staff were correctly putting on and taking off PPE and cleaning of high touch points.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to reduce the risks of infections spreading during a COVID-19 pandemic. This 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.

During and following the inspection we have signposted the provider and staff to resources to develop their approach. They updated us on positive action that has been taken to improve practices.

● Systems were in place to ensure the provider was preventing visitors from catching and spreading infections.
● Staff understood about shielding and distancing rules to reduce the risks of infections spreading.
● People and staff had access to testing in line with government guidance. When it was required people's capacity and consent had been considered.
● The provider's infection, prevention and control policy was up to date.
Learning lessons when things go wrong
● Inconsistent approaches to learning lessons when things go wrong were found during the inspection. Examples were seen where an issue had been raised to one locality manager and not acted upon. A different locality manager would then manage
● Medicine errors demonstrated learning did occur when something went wrong at one shared house. However, there appeared to be no systems in place to share the learning throughout the service.
● Accident and incident forms showed there was a system to identify when things went wrong and how to learn lessons. However, it was not clear how these lessons learnt were shared with all staff to prevent reoccurrence.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service was not well led. Quality assurance systems were not effectively being used to monitor and improve the consistency and safety of care for people across the service.
- Following an inspection of one of the provider's other services the provider informed us a review of quality assurance systems would happen including appropriately trained senior staff. At this inspection similar concerns about leadership and management were identified.
- The provider had put a seven-week plan in place to drive improvements before Christmas 2020. The provider's own review had identified shortfalls with the effectiveness of this plan.
- Quality assurance systems completed internally were not identifying issues found during the inspection to ensure risks to people were effectively managed. For example, medicine audits had not identified concerns with medicine management. Neither had the provider's quality and compliance team identified the issues around infection control and understanding how to safely use personal protective equipment (PPE).The provider's internal systems stated one 'home' was well led despite it being considered un-safe in their internal quality review. Following the inspection, the provider explained the internal quality team do look at PPE and told us it may be different staff working at the times of visits. The provider also told us the internal quality review was incorrect, by not following their policies and has now been reissued with well led no longer rated good.
- People were at risk of poor or inconsistent care because staff had not always followed the provider's own policies. Neither had staff followed best practice or national guidance in relation to medicine management and infection control practices.
- People experienced poor or inconsistent care because there was a high turnover of locality managers for the supported living services. Four locality managers met during the inspection had been in post for around four months or less. When there was an absence of locality managers, alternative arrangements were in place. However, the staff who were covering these roles reported that they sometimes felt unsupported and uninformed, for example, when guidance was often changing rapidly in response to COVID-19. This placed people at risk of infection spreading and national guidance not being followed. The registered manager had not identified this as an issue until we raised it with them during the inspection.
- Accident and incident review systems were not effective and placed people at potential risk of harm or abuse. Actions noted indicated that repeated concerns were not always resolved swiftly. Additionally, management had not identified potential patterns or concerns which could be safeguarding concerns. As a

result, people were placed at risk of abuse.
● The provider had developed systems to protect people during the COVID-19 pandemic. However, the management had failed to put effective measures in place to monitor the constantly changing COVID-19 pandemic guidance or that the systems they had were being followed. The registered manager had no systems in place to monitor the competence of staff using PPE and other systems in place such as regular cleaning of high touch points. There was a reliance on others completing these checks; we found they were not always being checked.
● The registered manager lacked effective oversight of the service leading to inconsistent care and, at times, unsafe care being delivered. Two supported living services had only been visited once in the last twelve months and three had not been visited at all in the last twelve months by the registered manager. This meant the registered manager was reliant in what they were being told rather than assessing the accuracy of the information. Following the inspection, the provider told us visits to services had been risk assessed and those with high level of concerns were prioritised.
● The provider was not proactive in identifying shortfalls and driving improvement with a reliance on external agencies. For example, since the inspection one of the homes we visited has now been reassessed internally with marked improvements. Improvements occurred in a shared house with significant safeguarding concerns where the local authority had been regularly holding the provider to account in line with their action plan. One health professional said, "In the cases I have been involved [in], it has been due to concerns raised by outside professionals, and improvements have been achieved by numerous multi-disciplinary team meetings, with [the provider] having deadlines for improvements."
● The provider was not ensuring the guidance 'Right Support, right care, right culture' was consistently followed across the service. This meant national statutory guidance was not consistently being followed to ensure the highest quality of personalised care for people. Paperwork and practices were inconsistent leading to people being placed at risk of harm or abuse. The turnover of staff was high which contributed to inconsistencies. For example, use of personalised communication systems, understanding individuals needs and use of restrictive practices were not always understood by staff.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during and after the inspection. They confirmed concerns found during the inspection had been rectified or plans were in place for improvements. Following the inspection, the provider informed us that prior to this inspection they had also started addressing a general concern about first line management in the services under the registration.
● The provider had clear expectations about the culture staff were to follow. This included how much support staff would receive when things were not going well including training needs and quality of care for people. Most staff told us about putting the person at the centre of their care. However, staff had mixed feelings about guidance they received and said it depended on their locality manager.

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
● Systems were in place to inform people and their relatives when things went wrong. There were mixed opinions from relatives about how information was shared with them. One relative told us about positive actions the staff take if there is a medicine error which could cause harm to inform people and their relative. So, the family member was reassured lessons have been learnt. Another said there was a delay in receiving any updates to an incident which had occurred involving their relative.

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

● Relatives felt throughout the COVID-19 pandemic they have been kept in contact with their family members. One relative when asked if they have stayed in touch said, "Oh yes, they even sent me some things that he had done; colouring and writing and stuff so they are very good yes." Another comment read, "We manage to speak every day on the phone, and she sounds cheerful."

● When relatives had concerns, they generally felt listened to and action was taken. One relative said, "If I have any concerns I speak to the [locality manager]. She really listens to me. She is very good." Another relative told us, "We have had issues, but they have been resolved." However, issues some raised were the changing of locality managers and not knowing who the registered manager was.

● Staff had mixed opinions of how well they felt listened to, including suggestions they had made. Some staff felt there was good support and any suggestions they made were listed to, but other staff did not. This appeared to be related to the management of the homes. For example, some staff members felt when they raised concerns or needed help these had not been acted upon by locality managers or even the registered manager.

Working in partnership with others

● Health and social care professionals had mixed views about the service. Positive comments were in relation to support staff provided when people were in hospital and meetings held about decisions when people lacked capacity. Concerns and improvements were often related to the instability of staffing, inconsistency in paperwork and changes of management in the homes. They felt this could place people at risk of harm or poor care.

● During the inspection, locality managers were responsive in contacting relevant health professionals when concerns were found. However, there were occasions when the information conveyed to the health professionals by staff was not as clear as it could be. Such as the need for people to have reassessments or speech and language therapy input when concerns were found.

● People saw other health and social care professionals when staff correctly identified a need. Actions taken by new locality managers demonstrated they were identifying when this had not worked so well. For example, locating physiotherapy plans which had not been reviewed or followed for people.

● Homes had systems in place to work with the local communities. Positive examples included people visiting local places of interest and using local shops and facilities.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of receiving unsafe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were placed at risk of potential abuse because staff using the systems in place were not always effective.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to manage and monitor safe and good care were not effective and placed people at potential risk of harm.