Lime Tree Care Ltd

Cherry Tree House

Inspection report

96 Creswell Road
Clowne
Chesterfield
S43 4NA

Tel: 01246451313

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cherry Tree House is a residential care home which provides personal and nursing care for 12 people at the time of the inspection. The service is registered to support a maximum of 18 people.

People's experience of using this service and what we found
Risks were not identified, managed or monitored to ensure people were safe and protected from harm.

Systems and processes to protect people from abuse and improper treatment were not robust. Staff did not have sufficient guidance in care plans and risk assessments to support people safely.

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. Capacity assessments were not always completed for people who were believed to lack capacity.

The provider had not ensured good oversight of the home to care for people safely or learn from when things went wrong. Incidents were not reviewed and audits that were completed did not identify areas of concern.

The provider had not always notified us of important events when required which is their legal requirement to do so.

Staff generally knew people well, had good relationships and knew how to communicate with them.
Staff were recruited safely, and all necessary pre-employment checks had been completed.

People had access to healthcare support when needed.

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

This service was registered with us on 10 June 2019 and this is the first inspection of this location.

Why we inspected
The inspection was prompted in part due to care concerns shared by external stakeholders. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

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

We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, governance and quality monitoring, staffing, respecting service user's dignity, consent to care and treatment and failure to submit notifications to the CQC, 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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well led findings below.

Inadequate

Cherry Tree House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Cherry Tree House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since registration. We sought feedback from the commissioners, local authorities and Clinical Commissioning Group (CCG) who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our

inspection.

During the inspection
We spoke with seven people who used the service about their experience of care provided. We spoke with twelve members of staff including the provider, nominated individual, registered manager, clinical lead, nurses, senior carers, carers and domestic staff.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at multiple documents and quality assurance records. We spoke with the GP and practice manager who support the service.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- The provider did not address known risks to the health and safety of people. People were assessed as being at risk from self-harming behaviours. Guidelines were not in place to safely manage items which could be used to self-harm such as: blades, ligature items and ingestible fluids. Daily audits completed by the management team did not identify self-harm risks in the environment. We found that people had been able to access such items and cause harm to themselves.
- Clear guidance was not in place for staff to safely support people who were at risk of choking, falling and poor health through not eating and drinking enough. We saw staff had been asked to make increased observations of a person, but they did not know why. The registered manager told us the person was at risk of falls. This had not been clearly communicated to staff through a risk assessment or verbally. It was not clear how the action plan implemented would reduce the identified risk of falling.
- The electronic system used to document individual's care and support was difficult to navigate and documents were not always easy to find. Staff did not have good access to the care records that were available. This increased the risk of harm to people as staff did not have guidelines for consistent care and support.
- People were not always involved in the planning and review of their care and support. One person told us they had developed a document for staff to help them to understand how to support them, but this was not found to be part of the person's care plan.
- Positive risk taking was not managed. Some people were assessed as requiring support to aid recovery and increase skills and independence. Staff did not have guidance to implement this for people to work towards these outcomes. Recommendations from external professionals were not necessarily shared. We saw where the acquired brain injury nurse had made recommendations to facilitate a person's recovery, but these were not found in the person's care plan.
- Some incidents which happened in the service were recorded. There was limited analysis of incidents by the registered manager to identify themes and trends. The provider told us steps were being taken to ensure all incidents were recorded and to improve the quality of records.
- The provider did not take action to prevent harm to people from further accidents and incidents. Analysis of incidents was minimal and did not identify themes and trends. Learning did not take place and the risk of harm to people was not reduced.

The provider failed to ensure care and treatment was always provided in a safe way. We saw people experienced actual harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being

reviewed currently and ongoing.

Using medicines safely

● People were at risk of chemical restraint due to the lack of guidance on when and how to administer "as required" (PRN) medicines. Protocols lacked detail on the circumstances in which these medicines should be given to people. There was not sufficient justification for the use of these "as required" medicines when they had been used to remedy signs and symptoms of anxiety and distress. This meant there was a risk people were administered these medicines unnecessarily and other methods to support the person were not sought.

● "As required" medicines were not always in stock and this posed risks to people's mental and physical wellbeing. We saw people's frustration and increase in anxiety when "as required" medication was not available to them when needed to support them to manage their emotions. Failure to ensure these medicines were available to people placed them at risk of harm.

● Medication management systems were poor. Both printed and hand-written medication administration records (MAR) were in use, the clinical lead and nurse on shift offered differing explanations as to why this was happening. However, the provider's policy states printed MARs should be used. Stock checks of medication were not recorded.

● Administration and storage of medicines were not clearly recorded and managed in line with best practice guidelines. There were errors and gaps in administration records and there was a lack of explanation where people did not receive their medicines. We found the medicine room exceeded the temperature for recommendations for safe storage. No action had been taken to address this.

● The weekly audit completed by the management team did not identify these issues and action was not taken to ensure safe use of medicines.

The provider had not ensured people's medicines were managed and administered safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

Preventing and controlling infection

● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely in accordance with government guidance. We saw staff touch their masks and not remove or replace masks during breaks. This increased the risk of spreading disease, including COVID-19. We told the provider who said they would take action to remind staff of guidance in the use of personal protective equipment. We did not see evidence of this during day 2 of this inspection.

● We saw PPE stored in hallways on bannisters around the home which increased the risk of cross infection.

● We saw areas of the home that were not clean, for example stained carpets in hallways and food debris on place mats in the communal area.

● Handwashing facilities were not available in the medicine storage area. Staff were unable to wash their hands before or during administering medicines. This put people at risk of contamination and cross infection.

The provider did not ensure infection control procedures were effective. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being

reviewed currently and ongoing.

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

We have also signposted the provider to resources to develop their approach in line with current guidance. For example, storage of PPE.

Systems and processes to safeguard people from the risk of abuse
● Practices and systems did not protect people from the risk of abuse. The provider had not consistently identified safeguarding concerns or raised alerts with the local authority to ensure a suitable investigation was carried out and to protect people from potential harm. A number of safeguarding incidents were being investigated by the local authority safeguarding teams which had been raised by external stakeholders. The log of safeguarding investigations did not match the record of safeguarding incidents recorded by the registered manager.
● People were at risk of inconsistent, unsafe physical intervention. Positive behaviour support plans did not provide guidance for staff how to respond when people were distressed or at risk of self-harm. Guidelines did not identify people's triggers or what physical intervention support people needed to keep themselves and others safe. One member of staff told us "there is no plan in place to support someone, I do it from experience".
● Positive behaviour support plans were insufficient to keep people safe from unnecessary or prolonged physical restraint. We saw on one occasion several instances of restraint happened within a three hour time period. Best practice guidance was not followed, which states: for any intervention to be proportionate and for the least possible amount of time to keep people safe.
● Some staff were not sure if they had attended safeguarding training. Staff told us they would report concerns to the manager, no staff told us they had experience of doing this. Staff did not demonstrate knowledge and competence in identifying and reporting safeguarding concerns for the people who used the service.

The provider has not ensured people were safeguarded from abuse and improper treatment. 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.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

● Some people told us they felt safe using this service. This was not the view of every person we spoke to.
● Most staff had completed online safeguarding training. Staff were confident they would report concerns to senior staff but did not have experience of doing so.

Staffing and recruitment
● Staff did not always demonstrate the skills or competence required to support people safely. Staff did not understand the need for written guidance to inform consistent support to people.
● Some people were identified as needing one to one support to keep themselves and others safe from harm. Staff did not have guidelines for providing one to one support. People were at risk of over restrictive and inconsistent support.

● There were sufficient staff numbers of staff to support people, however, deployment of staff was not carefully planned. We saw agency staff providing one to one support without receiving sufficient information to be aware of the risks involved. People were at risk of harm as because staff providing intensive support were not equipped or skilled to do so.

The provider did not deploy suitably qualified, competent and experienced staff to meet the needs of the people using the service. This was a breach of Regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

● Staff were recruited safely; all necessary pre-employment checks had been completed to ensure they were suitable to work with people who used the service.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DOLS).
We checked whether the service was working within the principles of the MCA.

- The service was not working within the principles of the MCA. People were at risk of unlawful restrictions on their liberty. We saw where a DOLS application had been assessed and agreed as necessary, but no application submitted.
- Care staff were not always able to demonstrate a good understanding of the MCA/DOLS process and how this impacted on people. Staff and managers were unsure if people had a DOLS in place and if any conditions were recommended. People were at risk of restrictions being imposed against their best interest.
- Records did not evidence people's involvement in making best interest decisions about their care. A person told us they were involved in decisions made about their care. However, capacity assessments were not consistently completed for people who were believed to lack capacity.
- Positive behaviour support plans did not ensure that restraint was used in a safe, proportionate and monitored way as part of a wider person-centred plan. Where restraint had been used it was not reviewed and monitored to ensure it was a proportionate response to protect people. Lessons were not learned to reduce the risk of improper treatment.

The provider did not always ensure consent to care and treatment was sought in line with legislation and guidance. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- The system used for risk assessing and care planning did not provide easily accessible information for staff

to follow. Some staff did not feel confident they knew the information in the support plans. One staff member told us "I get information about people from handover, not from care plans". People were at risk of inconsistent support.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Outcomes of assessments were not shared with staff to ensure safe, consistent support. Staff did not have guidelines to support people with diabetes or someone who was at risk of choking. One staff told us "one person was at risk of choking and required their food to be cut up into bitesize pieces". We found no assessment or guidance in place for this. People were at risk of harm as recommendations from professionals were not implemented.
● People were not always supported to maintain a balanced diet. We saw staff lacked competence and understanding to respond to a person who refused to eat. Staff were aware there was a risk if the person did not eat and drink regularly but did not have guidance to provide positive interventions to encourage the person.

The provider failed to ensure care and treatment was always provided in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

● We saw that people received input from the acquired brain injury team nurse, physiotherapist and occupational therapist. The GP practice supporting the service offered weekly calls to support medical issues as well as when required consultation.

Staff support: induction, training, skills and experience
● Staff did not have the necessary skills or competence to offer therapeutic support to people to meet people's complex mental health needs. Specialist mental health training was not offered to staff. One person told us, "Before I came here staff had not dealt with personality disorders or mental health". One staff told us "Staff are not trained enough to manage people; they are frightened of people."
● Not all the nursing staff employed had qualifications or experience in meeting the specialist needs of people using the service. Professional supervision and guidance were not available to develop mental health expertise. Staff did not have a full range of competence to meet people's needs.
● The provider chose an accredited model of positive behaviour support (PBS) and invested in a train the trainer system to provide in house training and specialist support within the service. We found overall the quality of PBS documentation not meeting the standards expected and staff did not have the specialist knowledge expected from this training in relation to identifying people's triggers and offering therapeutic intervention when people were experiencing anxiety and distress.

The provider did not deploy suitably qualified, competent and experienced staff to meet the needs of the people using the service. This was a breach of Regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

● Staff felt supported by senior and nursing staff. Staff supervision meetings were planned, and records filed when this took place.

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

● The environment met the needs of most of the people living there. People personalised their rooms with personal belongings and furniture. One person was very proud to show these to us, they told us, "Staff have helped me to make my room nice". Another person told us "I have had my room painted and put up canvasses".

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People's dignity and privacy were not always respected. During the inspection staff openly talked about people in communal areas. Some staff used inappropriate and undignified terms when talking about people. One person told us, "They (staff) whisper about us and talk about us even when we are in the same room".
- Staff did not demonstrate an understanding of people's diagnosis and models to support people's wellbeing. Some staff we spoke to described people's behaviours as manipulative, attention seeking, copied. People were at risk of harm to their emotional well-being.
- People were not always supported to be independent. Support plans did not include guidelines for staff to support people to work towards independence. One person told us, "I wanted to self-medicate, it has taken me ages to get staff to let me do it".

The provider did not ensure people were always supported by staff respecting people's dignity, privacy and independence. This is a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

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

- Some people had positive relationships with individual care staff. We saw positive, caring interactions between people and some staff members. One person told us, "Staff went out their way by getting a present to make my son's visit special." Another person told us "Staff are lovely and do genuinely care, they have gone above and beyond".
- Some staff supported people in making day to day decisions. We saw staff involving people in choosing activities to do that day. We also saw staff involving people in planning, preparing and cooking meals and offering people a choice of what to eat, at their preferred time place in the building.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated 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; Meeting people's communication needs; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's range of needs were not supported. Care plans did not include people's preferences, interests and aspirations. Staff did not have guidance on how to get to know people and understand what good days for people would look like. Staff had got to know people and how they liked to be supported but there were no guidelines for this to be consistent, quality care.
● Care plans were not person centred. Staff did not fully understand about person centred care. Care was not personalised even when preferences and choices were known. Staff followed task-based instruction such as, making regular checks on people without full understanding as to why these checks were being done but were not guided to plan active individualised support.
● Care plans and information documents were not provided in formats for people to be able to access easily if required. We did not see where people's communication needs had been assessed. Guidelines were not available to inform staff of people's preferred communication methods.
● People did not have a structured plan of activities and occupation. We saw activity boards in the service, but these were not kept current. One person told us "I don't know what I am doing today. I don't fill that in. I just tell them what I want to do". We saw people plan activities for that day but there was no structure in place for developing leisure interests or skills.

Improving care quality in response to complaints or concerns
● The management of complaints was inconsistent. The registered manager had logged one complaint; there was no evidence of complaints being investigated & outcomes shared. Learning from complaints to improve outcomes for people did not happen.
● The provider did not always take sufficient action to improve care. Concerns raised by external stakeholders after safe and well checks were completed and were brought to the attention of the management team. Action plans were developed and agreed but incidents were repeated.
End of life care and support
● An end of life pathway was implemented for people requiring support in this area. The registered manager

told us how this had been used to meet the needs and wishes of people who had been admitted from hospital.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

● The provider failed to ensure there was improvements made to people's care following incidents. There was minimal review of incidents by the registered manager. There was limited analysis to identify potential themes such as staff involved, interventions implemented and overall outcomes for people. Prior to inspection one person suffered a serious injury but there is no clear record in the care notes of how this happened. The review of the incident by the registered manager did not address the issue of why agency staff were in the position of providing one to one support and why risks of self-harm were not known. On the day of inspection, we saw agency staff had been deployed to provide intensive one to one support to another person and did not have sufficient information to understand and respond to risks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and their relatives had limited opportunities to express their views about the service or influence changes. The provider used surveys for people, staff and stakeholders to gain insight into their views of the service. At the time of inspection, the registered manager had not had opportunity to analyse these and was waiting on returns from professionals involved in the service.

● The provider did not take action to involve people in changes to their support. The provider responded to concerns into safe care and treatment raised by CQC by increasing 1:1 support for some people. This decision did not take into account the wishes, views and feelings of the people involved. One person told us they did not understand why their support had been increased and they were not happy about it. This demonstrated a lack of understanding of the complex needs of people and a lack of a person-centred approach.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager was unable to identify when incidents of self-harm, restraint and use of "as required" medication should be reported to the local authority or health commissioners. The review of the evidence indicated a lack of awareness by the registered manager of the overall level of governance required to manage and reduce the risk of harm to people.

● The provider failed to ensure people's mental capacity was assessed in line with the key principles of the Mental Capacity Act (2005). Systems were not in place to ensure compliance with the legal framework. The risk to people of unlawful restrictions was not managed.

● The provider failed to ensure a quality assurance or governance procedure was in place and quality audits were carried out regularly. This meant people's care, safety and welfare were not being monitored. Quality audits, where completed, had not identified the shortfalls found during the inspection. We identified ligature

risk items in the environment during the inspection. These were removed when brought to the attention of the provider.

● The provider did not undertake effective audits into the areas of management of behaviours that challenge, safeguarding, medicines, accidents and incidents, care plans and risk assessments to ensure good outcomes for service users. This meant people's health and safety were at risk.

The provider did not demonstrate effective governance, including assurance and auditing systems or processes. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

● Some staff felt the registered manager and clinical lead supported them day to day by being present and offering an open-door policy for any questions or concerns. Information obtained from other staff indicated a less positive experience.

● Notifications were not always submitted to CQC for serious incidents and safeguarding. The registered manager told us they understood their responsibility under the duty of candour to be open and honest when things went wrong. However, we were not assured of this because all notifiable information had not been reported to the CQC such as serious injuries, incidents or allegations of abuse. After the inspection we clarified notification expectations with the provider.

The provider failed to notify CQC of safeguarding incidents in line with national requirements. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider submitted a plan detailing actions they will take to mitigate the risks identified. This is being reviewed currently and ongoing.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify CQC of safeguarding incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not respect people's privacy, dignity and independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not seek to ensure consent to treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure adequate numbers of skilled, knowledgeable staff to provide good care.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and procedures did not ensure safe care and treatment for service users.

The enforcement action we took:

We imposed urgent conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and procedures did not safeguard people from harm.

The enforcement action we took:

We imposed urgent conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and procedures did not ensure good governance

The enforcement action we took:

We imposed urgent conditions on the providers registration