Aps Care Ltd

Stradbroke Court

Inspection report

Green Drive
Lowestoft
Suffolk
NR33 7JS

Tel: 01502322799

Date of inspection visit:
03 August 2023

Date of publication:
30 October 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Stradbroke Court is a residential care home providing accommodation and personal care to up to 43 people in an adapted building across 5 units. The service provides support to older people, some living with dementia and mental health conditions. At the time of our inspection there were 34 people using the service.

People's experience of using this service and what we found
Improvements were needed to ensure people always received good quality, compassionate, individualised and safe care as a minimum standard.

Risks to people were not always robustly assessed and mitigated. Staff did not always have the information they needed to provide safe care because risks associated with people's care had not always been fully assessed. This included risks relating to falls, diabetes, and choking.

There were not sufficient numbers of suitably skilled staff to make sure they could meet people's care and support needs; there had been a high number of unwitnessed falls in the service. Staffing levels were increased following the inspection.

Actions to detect, investigate and report allegations of abuse or neglect were not always sufficient. The local authority had received a high number of safeguarding referrals, which included concerns around people's sexual safety.

Infection control procedures required improvement. We found personal protective equipment (PPE) stored next to toilets, which posed a risk of cross contamination. The service was in significant need of redecoration. Paintwork was chipped in many areas and carpeting was worn. This meant that effective cleaning could not take place.

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 did not support this practice. Further work is needed to ensure mental capacity assessments and best interest decisions are in place for all aspects of people's day to day care.

People were referred to relevant professionals such as dieticians if people needed to gain weight. However, the current system in place for recording people's nutritional intake did not support the staff to clearly monitor what people had eaten daily, including any snacks to encourage weight gain.

Referrals were made to health professionals when there were concerns about a person's wellbeing. However, people's records did not always show the date of the visit or the guidance received. Care plans had not been updated to incorporate the guidance to ensure people received consistent care which met their

needs.

The staff training matrix showed gaps in staff training in areas such as first aid, falls awareness, and the Mental Capacity Act. Following the inspection, the care operations manager confirmed further face to face training had been booked in various subjects to ensure staff were up to date in their knowledge and practice.

Improvements were required to ensure that good practice in dementia care was being followed, such as designing and decorating premises in a way that supports people. There were no dementia care plans so staff had no information to understand when people were diagnosed, which subtype of dementia they had, and how this would affect their lives as it progressed.

Medicines were managed safely, and staff were recruited with suitable checks in place.

The provider's oversight and monitoring systems and processes had not been effective and failed to appropriately manage risks to people and ensure adequate numbers of skilled staff were deployed. Auditing systems had not always led to immediate improvements when issues were found. There were limited systems to gain people's feedback about their care, and feedback which had been received had not been used to drive improvements.

The registered manager was on leave at the time of the inspection, and there was a new manager in post. The provider was responsive to the inspection findings, they told us they were willing to learn, improve and share the actions they would take to address the issues found at this inspection.

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

Rating
The last rating for this service was good (published 25 December 2019).

Why we inspected
We received concerns in relation to the safety of people using the service and the high number of safeguarding referrals that had been made. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

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

You can read the report from our last comprehensive and focused inspections, by selecting the 'all reports' link for Stradbroke Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, governance, staffing, consent procedures and safeguarding.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Stradbroke Court

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was undertaken by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. The registered manager was on leave during our inspection and a temporary manager was in place. We will refer to them as the 'manager'.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 6 people who used the service and 6 relatives. We observed the interactions between staff and people using the service. We reviewed the care records of 7 people who used the service and multiple medicines records.

We spoke with 8 members of staff including the manager, care operations manager, deputy manager, trainee deputy manager, care assistants, senior staff and housekeeping staff.

We also reviewed records relating to the governance of the service, including incidents and accidents, 3 staff records relating to recruitment, training records and audits.

After the inspection visit, we received feedback from the services' administrator, and 1 healthcare professional. we spoke with the local authority safeguarding team, the provider's care director, and a further 7 relatives for their views on 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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Risks relating to people's care were not always sufficiently detailed or managed. Where people had specific health conditions such as diabetes or mental health needs, more detail was required to ensure staff had guidance on how to mitigate risk as far as possible. This also related to risks such as choking and falls. Not having the correct guidance for staff placed people at increased risk of harm.
- Where people had diabetes, there was no information recorded which demonstrated the warning signs and indicators of a person becoming unwell due to their condition and actions staff were to take. This was also the case for people who were at risk of choking; there was limited information about the signs and indicators of a person choking and actions staff should take.
- A person's records regarding their risk of choking identified they were provided with a soft and bite sized diet, however, a staff member told us their diet was of a different type. In addition, their records stated the person liked marshmallow type sweets, there was no indication in the records how these could be unsafe for people who were at risk of choking as they can expand when swallowed.
- There were a high number of unwitnessed falls in the service. Care plans did not always describe the equipment that was in place to mitigate risk, so staff were aware.
- The environment was not safe in some areas such as kitchenettes which people had access to. There was a risk people could come to harm from potential scalding or ingest items which could cause them harm.
- There were personal emergency evacuation plans (PEEPS) in place for each person accessible in the event of an emergency. However, those held within people's care plans were not always clear and some were contradictory.
- We were not assured the provider had systems to ensure the service was clean and hygienic throughout. We found the environment to be poorly maintained in many areas including worn carpeting and chipped paint on the walls, which did not support effective cleaning. We identified malodours throughout the service.

- In a kitchenette area, we found the coffee and sugar canisters had hardened coffee and sugar stuck to the inside and they were in need of cleaning. There was limescale around the taps and the grouting behind the sink was worn, this meant effective cleaning could not take place and could harbour germs and bacteria.
- Although there were cupboards in bathrooms for the storage of personal protective equipment (PPE), we saw open boxes of gloves and aprons near to a toilet and a hand wash basin, which posed a risk of cross contamination.

Systems had not been established to assess, monitor and mitigate risks to the safety of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we prompted the management team to replace the PEEPS in people's care files to the updated ones, which they did. The provider arranged for a fire company to visit to complete outstanding works within the fire risk assessment.
● We asked the fire service to visit to ensure exits were sufficient and staffing numbers would enable prompt evacuation. The fire service were satisfied that there were sufficient emergency exits, but advised a fire drill during the night to test if staffing numbers could cope with an evacuation.
● There were checks in place to ensure safe water systems to prevent legionella bacteria.
● There was an action in place for improvements needed to the environment already put in place by the provider.

Staffing and recruitment
● We were not assured there were enough staff working in the service to ensure they were always available to keep people safe and provide timely support where required.
● The service used a tool to assist them to calculate the staffing numbers required to meet people's needs. However, we were not assured this was effective as it did not take into account all factors, such as the layout of the building.
● During our visit, we found staff were not always present and available for people. For example, a person was walking around the service and said they could not find any staff to assist them. We saw a person was sitting uncomfortably on the edge of their chair, with the risk they may fall off of the chair, but staff had not noticed this.
● Some people were cared for in bed and would require 2 staff to assist with horizontal evacuation in the event of an emergency. We had concerns that the number of staff on shift at night may not be safe to complete an evacuation in a timely manner. The fire service also advised the manager to carry out a fire drill at night to ensure staffing numbers were adequate.
● Some staff had not received regular supervision. Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.

This constituted a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to our serious concerns about staffing levels we met with the care director following the inspection, and they increased the staffing levels both during the day and at night.
● Records showed staff had been recruited safely, including making the required checks. This included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Information provided to us by the local authority informed us of 4 current alleged safeguarding incidents under investigation. The local authority had shared information with us about concerns they had found in relation to incidents in the service and how these were being managed.
● We were not assured all safeguarding incidents were reported as required. We found 2 incidents which had not been reported.
● Actions had not always been taken promptly to mitigate risks relating to sexual safety.
● A person's records identified they entered other people's rooms which caused distress. A relative told us people often entered their family member's room and their personal items were missing. We were not assured that staff were deployed to ensure risks were reduced.
● Throughout our visit, we saw members of the public accessing the grounds of Stradbroke Court to walk

their dogs. We observed members of the public also walked up to people's bedroom windows, which posed potential dignity, security and safety issues.
● A relative told us they felt the service was not always safe. They said, "I come in [regularly] as I've been so worried about the care. On 1 occasion [family member] was sitting in bed soiled and there was an unwitnessed incident where [an injury was sustained]. There have been a number of unwitnessed incidents. Once [family member had an injury] and none of the staff noticed."

This constituted a breach of regulation 13 (Safeguarding service users from risk of abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection the provider arranged for fencing to be erected to prevent members of the public from accessing the grounds.

Learning lessons when things go wrong
● We were not assured the systems in place to learn lessons were robust. Accident and incident forms did not always demonstrate robust actions were taken when incidents occurred between people. The local authority also raised this as a concern during their visits.
● The management team had been working with the local authority and had formulated a more robust incident/accident form to show trends.
● Our inspection findings evidenced the quality and safety of the service had significantly deteriorated since our last inspection.

Using medicines safely
● There were systems in place for the safe storage, administration and management of medicines.
● Records demonstrated people received their medicines as required.
● People told us they received their medicines when needed. A person said, "I've been here that long they know all about me. They've sorted out my medicines." A relative said, "Medication is okay we have an annual assessment."

Visiting in care homes
● People told us they could have visits from family and friends, this was confirmed by relatives and our observations on the day of our inspection visit.
● As well as visits, people were assisted to keep in touch with their relatives which reduced the risks of isolation. A relative said, "We do see [family member] on the video which is reassuring." Another told us, "The staff organise a video call with [family member] every week."

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 good. 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
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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty.

- Care records did not always include capacity assessments on each area of people's care where they needed assistance with making decisions, for example with medicines, or sensor mats which enable staff to monitor people's movements.
- It was not clear from records if people had capacity or lacked capacity; there were contradictions in records.
- Where there was reference to individuals appointed to make decisions on people's behalf, there were no best interest decisions recorded. Therefore, we were not assured the service had robust systems in place to assess capacity and ensure decisions had been made in people's best interests.
- A person's records stated there was no individual appointed to make decisions on the person's behalf, however, a family member had signed to consent to the support provided with their medicines.
- The service had made applications for DoLS. However, some were from as far back as 2018. These had not been followed up by management to see what stage they were at or if they were still required to ensure people's care was the least restrictive and in line with the MCA.

Systems had not been established to assess people's capacity. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- Where people had lost weight, we saw referrals had been made to dieticians and food charts were in

place. However, the current system did not support the staff to clearly monitor what people had eaten daily, including any snacks to encourage weight gain. When we brought this to the attention of the management team, they implemented new food charts which would enable a better level of monitoring.

● We received mixed views about the food provided. A person told us, "In the last couple of weeks the food is improving. There is a choice of main meal at lunchtime, and you can have whatever is available at breakfast. They do sandwiches at teatime…If you feel hungry you can always ask for more, no problem." Another person said, "There is a choice, but I like gravy meals. I get my [relative] to bring me [food they liked]. If there is nothing on I fancy, I get them to warm one up. I had a dry chicken burger today, not to my liking at all. The previous chef was a genius with the food [they] had available." Another person said, "The food is very good."

● We observed lunch service and found people were being assisted where they required help eating their meal.

● We saw people had access to drinks during our visit. Where people were at risk of dehydration, records were maintained on how much fluid was taken each day.

● A relative told us their family member had lost weight, "Before [family member] had lost weight, now getting better, [their] weight has increased and drinks okay."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● We couldn't be fully assured that people's needs had been completely and holistically assessed. This was because the care records did not demonstrate this. For example, there was not always sufficient guidance in place to prevent risks as far as possible.

● Best practice guidance was not always referred to or used to increase the effectiveness of people's care. This included best practice guidance for people living with dementia and relating to specific health conditions such as diabetes.

● The service had not ensured The Mental Capacity Act 2005 was being used to support people's decision making.

● Records showed referrals were made to health professionals when there were concerns about a person's wellbeing. However, people's records did not always show the date of the visit or the guidance received. Care plans had not been updated to incorporate the guidance to ensure people received consistent care which met their needs.

● People's records identified the support they required with their oral care.

● Relatives told us their family members were supported to access health professionals where required. A relative said, "Staff are quick to get a doctor or nurse."

● Prior to people moving into the service needs assessments were undertaken with the input from people and their representative, where appropriate.

Staff support: induction, training, skills and experience

● The staff training matrix showed gaps in staff training in areas such as first aid, falls awareness, and the Mental Capacity Act. Following the inspection, the care operations manager confirmed further face to face training had been booked in various subjects to ensure staff were up to date in their knowledge and practice. The provider had also planned to implement 'champion' roles, where staff have additional knowledge in a specific area such as safeguarding.

● People told us they liked the staff and felt they were trained. However, a person said there were communication issues with some of the staff who did not speak English as their first language.

● There was a staff induction programme in place. However, the provider had identified this needed to be more robust and has since made changes to this so staff are better supported.

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

● The service was surrounded by extensive grounds; some parts were pleasant and could be used by people using the service. However, there were several other parts where which were very overgrown and unsightly some with piles of bricks and rubble and did not provide an attractive view for people using the service.

● There were plans for extending the service, but the new management team had made the decision to put this on-hold. They had identified that the current service needed extensive improvements first.

● We noted the service was in need of significant redecoration throughout. The management team told us there was a programme of redecoration and refurbishment planned, along with an action plan which they shared with us including timescales to improve the service.

● Improvements were required to ensure that good practice in dementia care was being followed, such as designing and decorating premises in a way that supports people. For example, doors, seats, and handrails being in a contrasting colour.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Breaches of regulation we found at this inspection demonstrated that systems to assess and monitor the quality of the service were not sufficiently robust, and actions had not always been taken in a timely manner when issues were found. For example, there were trends in the times and places that people had fallen, but this had not been acted on immediately to reduce risk.
● The provider's oversight and monitoring systems and processes had not been effective and failed to appropriately manage risks to people and ensure adequate numbers of skilled staff were deployed. This placed people at risk of harm and may have affected evacuation response times in the event of an emergency, such as a fire.
● Not all incidents had been notified to CQC, such as a burn which was sustained from a person dropping hot fluids onto themselves, and an incident concerning an altercation between residents.
● Accurate, complete and contemporaneous records were not reliably maintained. For example, risk assessments and care plans did not consistently contain enough detail and MCA records did not adhere to the associated legislation. The care records did not guide staff in the current way of providing support to people.
● The systemic failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate placing people at risk of potential harm.
● Further work was needed to review the longer-term oversight of safety and quality at the service to ensure improvements are made, understood, embedded and sustained.

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

● There was a registered manager in post, but they were on leave at the time of the inspection. There was a temporary manager in post. They were supported by a deputy manager and the care operations manager. The new management team had been responsive to the concerns raised by us, and acted promptly to rectify these.
● Following the inspection, the care director gave assurances that immediate risks would be addressed such as increasing the staffing levels, and implementing robust care records. The management team also sent us a live action plan which was already in place, noting areas for improvement.

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

● People's records did not identify information which demonstrated person centred care, there was limited information about the person as an individual with diverse needs. There were no dementia care plans so staff had no information to understand when people were diagnosed, which subtype of dementia they had, and how this would affect their lives as it progressed.

● The provider was failing to ensure the service was being run with a focus for people living with dementia with complex and changing needs. The local authority confirmed they were reviewing people's needs and how these were being met within the home.

● We received mixed feedback from relatives about the management of the service and if it was well-led. A relative said, "I can talk with the manager and deputy manager. They are both really good and I do feel listened to." Another said, "I'm not convinced the management team are strong enough, but we will see."

● People told us they knew who the temporary manager was. A person said, "The manager at the moment is [name]. [They are] very good, listens and is approachable. Yes, very good." Another person said the temporary manager, "Seems okay."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager understood their responsibilities in relation to the duty of candour and communication with people when things went wrong.

● Relatives told us communication was improving, when things went wrong or if their relative was involved in an incident. A relative told us they had received a verbal apology from a member of the management team in a meeting but had not been provided with a written explanation nor was the apology documented.

● The provider acknowledged the failings but committed to putting things right, which included appointing a consultancy company in June 2023 to help with the on-going improvements.

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

● The provider's provider information return (PIR) told us people were asked for their views about the staffing levels in the service. There was no evidence to show this had taken place.

● The provider had limited systems to gain people's feedback on the service provided. Where feedback had been received, there was no evidence this was used to drive improvement, or that an action plan was in place.

● We asked people if they had attended meetings to talk about their views of the service and make suggestions. No one said they had attended meetings or been invited to them. A person said, "Not yet, no. I wonder if there'll be one soon. The staff are always asking me if I'm okay." Another person told us, "No. I can't say they do."

● A relative told us they felt their family member should be enjoying the final years of their life and they should be enjoying visits with their family member, instead they felt they were spending time attending meetings with the management and other professionals to discuss what had gone wrong.

● Relatives told us they were kept updated if there were concerns about their family member's wellbeing and attended individual meetings, but there were rarely relative meetings or requests for formal feedback about the service. The care operations manager confirmed that going forward these will be held monthly.

● Further education was required around people's sexual health needs and how this should be considered when planning people's care. The provider had plans to incorporate this into staff learning.

● Staff we spoke with said they enjoyed their roles and were happy with the management team. They recognised that improvements were needed.

Continuous learning and improving care

● Some staff had not received regular supervision. This meant staff did not receive constructive feedback on their performance to support them to improve. The provider needed to ensure staff understood the training they received and that it was completed on a regular basis. More robust oversight in relation to staff training was required to ensure staff remained skilled and up to date with their learning.

● Lessons had not always been learnt to improve the safety and quality of the care that people received. For example, there were a high number of unwitnessed falls which may have been as a result of poor staffing levels.

Working in partnership with others

● The service had worked closely with the local authority.

● People were referred to and reviewed by external health professionals such a SALT (Speech and language therapy). However, care records did not always reflect up to date information about recommendations made by professionals involved in people's care and treatment.

● A healthcare professional told us, "During our visits we have been working alongside the manager and the regional manager. We have been working together to help with the upcoming changes which are needed and so far we have noticed positive change that have taken place."

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 11 HSCA RA Regulations 2014 Need for consent The provider was not working in line with the Mental Capacity Act 2005, to ensure people's care was lawful. Mental capacity assessments and best interest decisions were not always in place. Applications for DoLS were not followed up to ensure they were still required, and that this was the least restrictive option. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to people's care were not always sufficiently detailed or managed. Items which could pose a risk to people were accessible. Infection control procedures required improvement, including storage of PPE. 12 (1) (2) (a) (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents had not always been

identified or reported. We were not assured staff were reporting concerns with unexplained injuries. Actions had not always been taken promptly to mitigate risks relating to sexual safety.

13 (1) (2) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's oversight and monitoring systems and processes had not been effective and failed to appropriately manage risks to people. Accurate, complete and contemporaneous records were not reliably maintained. For example, risk assessments and care plans did not consistently contain enough detail and MCA records did not adhere to the associated legislation. Not all incidents had been notified to CQC. 17 (1) (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to ensure people's safety and monitoring. 18 (1) (2) (a)