SHC Clemsfold Group Limited

Beechcroft Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Beechcroft Care Centre is a residential nursing home providing personal and nursing care for up to 30 people with the following support needs: learning disabilities or autistic spectrum disorder, physical disabilities, younger adults. At the time of our inspection there were 15 people living at the service, and one other person who had been living with their parents during the Coronavirus pandemic. There were three lodges (Beechcroft, Chestnut and Hazel) which made up the service. During our inspection Chestnut Lodge was temporarily closed and everyone lived in Beechcroft and Hazel lodges. Each lodge had its own dining area, lounge, medicines room and kitchenette. People had their own en-suite rooms.

Beechcroft Care Centre is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns previously raised, the provider is currently subject to a police investigation, although this does not affect Beechcroft Care Centre specifically. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found
People were not receiving safe care and treatment. We found risks around people's feeding tubes, behaviours that may challenge others, constipation, epilepsy, reflux, choking, and monitoring people's health needs were not being managed safely. Systems to protect people from possible neglect or abuse were not effective.

Staff did not have the competencies to support people with behaviours that may challenge others. Lessons had not been learned consistently. We found learning from a hospitalisation had not been shared with the registered manager. Some issues we raised during previous inspections were still present, despite the provider giving us assurances these had been put right. The culture at the service was not always person centred. Outcomes for people were not positive and there were times we saw people supported in a way that was not safe.

Audits had not been effective in highlighting issues found at this inspection or improving the care and support people received at Beechcroft Care Centre. Management of the service was not effective and had not ensured the necessary improvements were made.

Beechcroft Care Centre was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People's experience of care was not always person centred such as at mealtimes or during activities.

Medicines were being managed safely, and people's medicines were being counted and stored correctly. People had been receiving support with physiotherapy in the two months before our inspection. The provider was working with other agencies to deliver care to people. The service was clean, and people were

being protected from infection control risks, including Covid-19.

The model of care and setting did not maximise people's choice, control and independence.
Staff wore uniforms and had name badges to say they were care staff when supporting people. The service is bigger than most domestic style properties. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of the service to indicate it was a care home.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.
The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. People did not always receive person centred care at mealtimes or with their activities.

Rating at last inspection
The last rating for this service was Inadequate (published 9 December 2020).
At the last inspection we found multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 11, 12 and 13 December 2019 and an announced focused inspection in September 2020. Breaches of legal requirements were found at both inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding service users, and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has stayed at Inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Beechcroft Care Centre on our website at www.cqc.org.uk.

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 people from abuse, good governance, and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-

inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Beechcroft Care Centre

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 on both days by two inspectors.
Beechcroft Care Centre 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.

Service and service type:
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 the last inspection. 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 four people who used the service and three relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, deputy manager, registered nurses, senior care workers, and care workers. We also spoke with the provider's nominated individual. 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 six people's care records and multiple medication records. We looked at two staff files in relation to staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We reviewed copies of people's care and records, rotas, incident reports and audits. We spoke with the registered manager. We also spoke with three support workers, one registered nurse and three relatives of people using the service via telephone.

Inadequate

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 Inadequate. At this inspection this key question has now remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● At the last inspection in September 2020, we found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risks associated with choking, feeding tubes, epilepsy, constipation, reflux, and behaviours that may challenge others had not been recognised and addressed. At this inspection not enough improvement had been made and the provider remained in breach of Regulation 12.

● Risks around choking had not been managed safely. One person had care plans, and guidelines written by an NHS dietician that set out the support they needed to eat and drink safely. This included being supported to eat slowly and being given the chance to feed themselves. However, we observed two lunch services for this person where this did not happen.

● On both lunch services the person was not offered the chance to feed themselves. In addition, they were being supported to eat very quickly. For example, they ate their main meal in four minutes and a dessert in one minute whilst being supported by staff who were holding the cutlery. We also saw instances where the person was given drinks by staff whilst laying on a bean bag in an unsafe position. This left the person at risk of choking.

● The same person was frequently not achieving the recommended allowance of fluids. There was a risk identified that the person could suffer more seizures or experience constipation if they did not drink enough. However, their dehydration risk assessment failed to recognise they regularly refused fluids. Their support recorded that staff regularly offer drinks but there were sometimes two-hour gaps between the person refusing a drink and staff offering another.

● The person's latest dietician's review report noted staff should refer the person back to the dietician if further input was needed. There was no evidence that this had been done, although it was recorded the person had not been drinking enough in the period since the review was carried out in November 2020. This period also corresponded with episodes of prolonged constipation, which was a known risk.

● There was a period in January 2021 when the person did not receive their constipation medicine as directed. This was during a time when the person was not drinking their recommended amounts. They should have received their 'as required' medicine after two days of not opening their bowels. However, they did not receive this medicine until three days of not having their bowel open. This put the person at risk of discomfort and health complications from constipation. At our last inspection we raised concerns about 'as required' medicines for constipation and were given assurances this was addressed with nurses.

● From the person's notes it appeared the registered nurses were unclear about when the person had last opened their bowels due to poor recording. There were other examples of poor recording of bowel care, such as not recording on the reverse of medicine administration charts when and why medicines had been given. This left people at risk of not receiving their assessed bowel care.

● A second person had a long-term condition affecting their bowels that had required hospital treatment in

the past on several occasions. Their care plans stated that if they vomited or their stomach was distended staff should call 999 immediately. The person vomited in January 2021 and staff gave anti-sickness medicines instead of calling 999.

● We spoke to the registered manager about this and were told the person appeared unwell and was then OK later in the day and had 'as required' medication for vomiting. However, the person had also been showing signs of constipation in the days leading up to vomiting. They had not drunk as much as usual and had watery stools. This risk had not been picked up or acted on by staff. This left the person at risk of health complications.

● The person's 'bowel function' risk assessment did not mention the long-term health condition, or the possibility of their bowels being blocked. The person's 'My Health Passport' did not explain the seriousness of the condition or what action staff needed to take.

● One person had behaviours that may challenge others. The risks associated with the safe management of these behaviours was not being managed effectively, or in line with best practice. The person was being supported by staff who told us they supported them in a certain way to help calm them. This was not in any of the person's care plans or risk assessments. The person's care plan stated that behaviours that may challenge others were 'historic', but staff and incident forms told us these behaviours were current and frequently presented.

● Agreed and planned strategies, such as coping strategies and activities to engage the person, were not being used by staff to help the person with their anxieties. When staff needed to move away from the person when they presented challenging behaviours, there were no directions about how to do this safely.

● There were no directions on how to safely physically re-direct the person if they would not let go of staff hair. Similarly, there were no directions around how long to leave the person for after an incident. We observed several occasions where staff were visibly uncomfortable and overwhelmed and required other staff to intervene. This puts the person at risk of inappropriate or unsafe physical intervention that is not being safely monitored or managed.

● Risks to people who received their food, nutrition and medicines via feeding tubes had not been assessed and mitigated safely. People with feeding tubes were required to have their feeds paused for at least 30 minutes prior to staff supporting them to move. This is to reduce the risk of choking or aspiration (breathing in liquids, food or saliva) which can cause pneumonia.

● We looked at the care records for two people with feeding tubes and they were not being supported safely. On several occasions one person's feeds had not been paused for 30 minutes before being supported to move. We found instances where they had been moved after 14, 15 and 20 minutes after their feed was paused. The safe time for moving this person after pausing their feed was 30 minutes. This left the person at risk of choking or aspiration

●There were multiple examples of a second person being supported to move too soon after their feed was paused. On one occasion the person had been moved only two minutes after their feed was paused.

● The same person needed to be supported at a specific angle in bed for 30 minutes when they had their feed, fluid or medicines. We found this was not happening consistently and there were times when they were only at the correct angle in bed for one minute. We also found instances where their feed was paused for 24 minutes before being restarted. They had been supported with a hoist, received personal care, and hoisted again in this time. This left the person at risk from choking or aspiration. We found the same issue at the last inspection and were given assurances that staff responsible had been trained. However, at this inspection we found numerous staff had documented incorrect pauses.

● Risks related to reflux had not been managed safely for one person. The person had been diagnosed with reflux, had been prescribed medicines for this condition and had a sleep system for night-time use. Their guidelines stated the person should lay with their bed tilted to reduce the risk of aspiration. However, this had not been done and the person had been laid on a flat bed.

● We spoke to the deputy manager who confirmed the person was on the wrong bed and by the second day

of our inspection the person's bed had been changed to one which could be tilted. The guidelines staff were using were incomplete and a mixture of two different guides. Staff we spoke with about the support the person had at night were not clear about how they should be supported. The person's reflux risk assessment did not state the need to angle the bed and other care plans failed to mitigate the risks of reflux. This left the person at risk of choking or aspirating at night-time. At the last inspection we raised concerns about people with reflux laying flat in bed and following our inspection we were given reassurances around this.

● Other risks were not being managed as safely as they could have been. One person was at risk from falls and was assessed as needing specialist equipment to support them to stand and walk Staff told us that the person did not like using it, so they did not try and use it. We observed the person being supported to walk in a way that was not in line with their mobility care plan and put the person and staff at risk of falls and other injuries. We did not see any referral to professionals for advice to manage this risk

● Some people with skin that was at risk of breakdown had mattresses that were controlled with an air pump to reduce the pressure on their skin. These are designed to be set to people's weights. We checked two of these pumps and they had been set to incorrect weights for the people. This put them at risk of developing pressure wounds or skin breakdown. The provider told us this may be due to electrical safety testing on the day.

● People who were at risk from deteriorating health were assessed as needing to be monitored with a tool called the National Early Warning System (NEWS). NEWS is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. NEWS involves taking a baseline for a person's normal temperature, pulse rate and oxygen saturations. It then states what actions should happen if results are recorded outside of the baseline.

● One person had epilepsy and experienced regular seizures. Their epilepsy care plan stated staff should record a NEWS chart after any seizures. However, staff were not taking NEWS recordings following a seizure and there were often long delays in taking observations. For example, we found times when following a seizure, the NEWS chart was not taken for an hour or more. This put the person at risk of their health deteriorating and staff not being aware. At our last inspection we raised concerns around the safe use of NEWS charts and were given reassurance that this had been addressed.

Learning lessons when things go wrong

● Lessons had not consistently been learned to ensure people received safe care. There had been some areas of improvement, such as around safe management of medicines. However, there were areas where lessons had not been learned and people remained at risk of harm.

● One person had been in hospital with complications around constipation. The provider' condition report submitted to CQC highlighted that this was an avoidable admission to hospital if bowel monitoring in Beechcroft Care Centre had picked up constipation. The registered manager and deputy manager were unaware of this finding, and therefore had not taken action to reduce the risk of it happening again.

● Following our last inspection in September 2020 we were given assurances that people's PEG care was improved due to staff training and supervision and people's care plans were updated. However, during this inspection we still found issues with PEG care and people were not receiving care as per their care plans. We also raised concerns around bed angles for people with reflux, the use of 'as required' medicine to treat constipation, and the use of NEWS charts to monitor people's changing health. Despite being given reassurances following our last inspection we found concerns in all of these areas at this inspection.
The failure to provide consistently safe care and is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were receiving support with their physiotherapy needs. Most people who lived at Beechcroft Care Centre were assessed and funded for physiotherapy and hydrotherapy. Where hydrotherapy sessions were unable to be provided (due to Covis-19 restrictions), people were receiving extra physiotherapy support sessions.

Systems and processes to safeguard people from the risk of abuse, and learning lessons when things go wrong.

● At the last inspection in September 2020 we found a continued breach of regulation 13 relating to safeguarding people from abuse and neglect. At this inspection we found that not enough action had been taken and the breach remained.

● People were still not receiving their care in and treatment in line with their assessed needs. For example, one person had not received their constipation medicine when they needed it. People were not being supported safely with feeding tubes, behaviours that may challenge others, or choking risks. These examples of possible neglect had not been identified by the provider or the registered manager.

● Systems for staff and managers to report, review and investigate safety and safeguarding incidents were not always effective. Systems and processes had not been established and operated effectively to immediately investigate, any allegation or evidence of such abuse, as managers and the provider were not aware of issues until we raised it with them. Prior to our site visit we were made aware of an allegation of neglect where a person had been moved in an unsafe manner. This same issue had been previously raised with the service during inspection in December 2019.

● The failure to implement systems that effectively prevent abuse is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations .

Using medicines safely

● At the last inspection in September 2020 we found a continued breach of regulation 12 relating to the safe management of medicines. There were not robust or effective processes for managing the stock of medicines or the use of as required' medicines. At this inspection we found that improvements were made, and the breach had been met.

● Medicines were being managed safely. Stocks of medicines were being checked and counted regularly so that registered nurses were aware of how much of each medicine was in stock.

● We observed two medicines rounds and registered nurses supported people to take their medicines safely and in line with best practice. Medicines were being stored in the correct way.

Staffing and recruitment

● Not all staff had the competencies and skills to support people safely. Staff had not received effective training in positive behaviour support. This had affected how people were supported. For example, staff did not appear confident or to have the necessary skills or knowledge to deliver safe and effective positive behaviour support [PBS], or safe eating and drinking support for one person.

● We discussed the PBS training with the registered manager who showed us that staff had received a competency assessed training. However, this training to the staff team had not been delivered by a skilled PBS practitioner. We discussed PBS training with the provider's nominated individual who confirmed that the provider had plans to bring PBS specialist staff into the organisation and upskill staff.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

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 Inadequate. At this inspection this key question has remained the same. 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.

Continuous learning and improving care; 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

- At the last inspection in September 2020, we found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We found the provider's governance framework was not consistently robust in driving improvement and addressing shortfalls in the provision of care. At this inspection not enough improvement had been made and the provider remained in breach of Regulation 17.
- At our last inspection we raised concerns around safe care including feeding tubes, choking, constipation, epilepsy, use of NEWS charts to monitor people's health, and reflux and aspiration risks. Despite some improvements being identified around medicines management and physiotherapy provision at this inspection, we found that concerns remained in relation to the safety of care with feeding tubes, positioning, reflux, choking and the safe management of behaviours that may challenge others.
- The provider had given assurances following the last inspection that feeding tubes were being managed safely but we continued to find these were unsafe. We also raised concerns in September 2020 about one person's risk of reflux at night-time and were told this had been resolved. We found this remained a risk and the provider had to change the person's bed during our inspection and take immediate action to re-assess the risk to ensure the person was being supported safely. Similarly, we identified risks relating to the use of NEWS charts at the last inspection and were given assurances but found issues with NEWS charts at this inspection. This does not demonstrate a culture of continuous learning.
- Beechcroft Care Centre had not been rated Good in well- led for four previous consecutive inspections going back to 2018 and had been rated as Inadequate in Well led for the last three inspections. This is the fifth consecutive inspection that the provider has been in breach of Regulations 12 and 17 relating to safe care and treatment and good governance. Following each of these inspections we were sent an action plan setting out how the provider would ensure improvements were made. Despite the action plans and assurances received we found sufficient improvements had not been made at this inspection and the service remains in special measures.
- At this inspection we found people were still not consistently safe from a range of risks, including risks related to constipation, epilepsy, behaviours that may challenge others, choking, moving and handling people, and monitoring people's health needs. Staff did not have the competencies to support people with their behaviours, and people were not being protected from neglect or abuse, as systems to protect them from possible abuse were not effective.
- The provider's quality audits had not been effective in identifying all areas of concern, or in responding to concerns we had previously identified. There had been a new review of quality in the week prior to our

inspection, that had highlighted several areas for improvement but there had not been time to effectively share or embed the learning from this audit.
● People with behaviours that may challenge others had ABC charts. ABC charts are used to track what happens before, during and after an incident to learn from them, and to reduce future instances of behaviours of concern. We were not assured that ABC charts were being effectively completed or monitored. One person with frequent behaviours only had three ABC charts completed and one of these did not have a review of actions. This left people with behaviours that may challenge others at risk of not receiving safe support.

● In December 2018 we imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at several services operated by the provider.
● The conditions mean that the provider must send to the CQC, monthly information about accidents and incidents, unplanned hospital admissions and staffing and how they are acting to resolve any risks to people's safety and wellbeing.
● The provider level conditions and reporting of information about themes of unsafe care for people being supported by the provider had not led to similar risks to people at Beechcroft Care Centre being reduced.
● Concerns about risks associated with constipation, epilepsy, feeding tube management, effective use of NEWS, reflux, and moving and handling people have all been repeatedly highlighted to the provider at other of their services. This information had not been properly shared or used to improve safety and quality at Beechcroft Care Centre.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Despite seeing some improvements in some areas, such as safe management of medicines, we identified continued concerns that had been raised at previous inspections.
● There was a registered manager in post. 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.
● At our last four inspections the registered manager and provider had told us about action they had taken to put things right. We found this had not happened or been sustained. At this inspection not enough action had been taken to make improvements and breaches of Regulations remained. The registered manager and the registered provider have a duty as part of their registration with CQC to ensure the service was compliant with Health and Social Care Act (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Regulation 17 requires providers to continuously assess, monitor and improve the quality of their provision. However, the provider's own quality monitoring processes had not identified or remedied issues around activities provision. Not all support was person centred or inclusive. We reviewed people being supported during activities and lunch services. One person was not supported in a caring or person-centred way when they were distressed. Staff were not confident in supporting the person safely with their distress and did not follow assessed and agreed strategies.
● We observed other people being supported with activities such as craft or cooking. The activities were arranged in a group with between six to eight people being supported. Some people required different levels of engagement and communication and did not receive this. After a while some people looked disengaged and bored as the activities were not tailored to their needs.
● In one instance a person's only engagement during a cooking activity was being shown a cake mixture in a

bowl for a few seconds but was not supported to spend time mixing the cake. This person enjoyed sensory activities, such as making cakes or 'messy play', but did not have this support. This meant people's experiences and outcomes were not consistently positive.

●We found other examples where people had not always been supported in a positive, inclusive or empowering way. For example, not being supported to be as independent as possible when being supported to eat. Staff had not followed directions in a person's care plan to help them understand their emotions better, which could enable the person to learn how to recognise and have more self-control over preventing and reacting to situations where their behaviours could becoming challenging. This reduced the chances of people achieving good outcomes from their support and impacted their quality of life in a negative way.

The failure of the registered provider to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, is a continued Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others

● The registered manager described good working relationships with partner agencies. There was a GP, tissue viability nurse, chiropodist, speech and language therapist, dieticians, dentist and the local authority safeguarding adults team all involved in the service. The registered manager and staff team have supported people to access online meetings and video calls for reviews and assessments when face to face appointments were cancelled due to Coronavirus restrictions.

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

● People and staff were encouraged to be involved in developing the service. There was a box for staff ideas. At the end of each month managers review the suggestions such as staff asking for things to make the service more homely. There was also a staff 'reps' meeting every month. A questionnaire went out to all staff which was returned to the provider. We saw that staff had started to change the décor in the service, and this has been done in one lodge.

● There were regular meetings with people, where they discussed the menu or activities.

● Staff were trying to communicate with some people in accessible ways. One person used a hand signal to indicate yes or consent, and we saw staff recorded when they used this to engage the person.