CareTech Community Services Limited

CareTech Community Services Limited - 196 High Street

Inspection report

196 High Street
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Care Tech Community Services Limited 196 High Street is a residential care home providing personal and care to up to 12 people. The service supports people with learning disabilities and autistic people. At the time of our inspection there were 6 people using the service and 6 people were on holiday.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the services supported this practice. People's care was not personalised. The home was not well maintained. The provider did not have effective processes or systems in place to deal with the repairs that were needed in the home to keep people safe. The provider was struggling to recruit permanent staff which meant there was a high use of agency staff, and this impacted on how people received their day to day care and support. Medicines were administered safely. The provider had safe infection control practices. Staff understood how to raise safeguarding concerns.

Right Care:
People received kind and compassionate care. Staff did not always protect and respect people's privacy and dignity. Permanent staff understood and responded to people's individual needs however some agency staff did demonstrate they had the necessary skills to care for people. Support plans didn't always reflect people's interests and activities and there was a lack of activities at the home which meant some people did not participate in activities they enjoyed. People were supported to access healthcare services. People were supported to maintain balanced diets.

Right Culture:
The service was not well-led. There was no effective governance system in place to monitor the quality of the service provided to people. The provider was not learning from incidents and accidents which placed people at risk of harm. Based on our review of this service the service was not able to demonstrate how they were meeting some of the underpinning principles of Right care, Right support, Right culture.

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

Rating at last inspection and update
The last rating for this service was good published (22 August 2018)

Why we inspected
The inspection was prompted in part by a notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about assessing risk. This inspection examined those risks.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Care Tech Community Services Limited 196 High Street on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches of regulations in relation to person-centred care, safe care and treatment, premises and equipment and good governance.

We have sent a Regulation 17(3) Letter to the provider in relation to their failure to effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activities. A Regulation 17(3) Letter stipulates the improvements needed to meet breaches of regulation, seeks an action plan and requires a provider to regularly report to CQC on their progress with meeting their action plan.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore '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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
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 responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

CareTech Community Services Limited - 196 High Street

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.

Inspection team
One inspector carried out the inspection.

Service and service type
Care Tech Community Services Limited 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.

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 reviewed a range of records related to 3 people's care and support. We looked at the medicine records for 2 people and 2 staff files in relation to recruitment and training. We reviewed records related to the management of the service, which included training records, safeguarding incidents, complaints, quality assurance records and a range of policies and procedures. We carried out observations of care and support. Our observations included the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We spoke with the deputy manager, team leader, 3 staff members and 3 people who lived at the home. After the inspection we contacted 3 professionals, and we received feedback from 1. We spoke with 5 relatives.

Requires Improvement

Is the service safe?

Our findings

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

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

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

- The provider did not always have effective arrangements to help protect people from risks associated with the environment. Systems in relation to fire had not been upgraded by the provider following a fire risk assessment completed on 07 June 2022. For example, there were 3 fire doors which were in need of repair which meant they did not close correctly, despite concerns being raised by staff these were not fixed which placed people at risk of harm.
- The lift had been condemned which serviced the first floor. One person lived on the second floor, had mobility difficulties, but the provider had not updated this person's risk assessment for using the stairs.
- During a tour of the building we identified trip hazards which had been logged by staff to the maintenance team, but no action had been taken to mitigate the risk of trips and falls.
- The provider had systems to log incidents and accidents as they occurred in the service, but lessons were not always fully learned following serious incidents.

Systems had not been established to assess monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the provider submitted an action plan to address the concerns raised.

- People's physical health risk management plans were updated for people and when required appropriate referrals were made to relevant professionals.

Staffing and recruitment

- People were supported by an adequate level of staffing. However, the provider was using a high number of agency staff, whilst agency staff had the necessary training, permanent staff spoke about the negative impact this had on the day to day running of the home. Staff told us it took agency staff significant longer to get to know how best to support people.
- People also spoke about the high use of agency staff, 1 person said, "It is frustrating for us as we can't go out and do stuff. "The provider was actively recruiting staff and senior staff acknowledge the issues the sector was facing.
- New staff were recruited safely. The provider had safe recruitment practices in place. We looked at 2 newly recruited staff files. These included evidence staff had the relevant previous experience and qualifications. Checks were carried out to ensure staff were suitable before they started working for the service. This included obtaining references from previous employers, reviewing a person's eligibility to work in the UK,

checking a person's identity and ensuring criminal record checks were completed.

Using medicines safely

● Medicines were managed safely. We reviewed the medicines administration records (MAR) for 2 people who used the service and saw these were completed correctly and staff signatures corresponded to the stock, indicating people were receiving their medicines appropriately and as prescribed.

● The staff member we spoke with had excellent knowledge about medicines and people's needs regarding these.

Systems and processes to safeguard people from the risk of abuse

● Staff knew how to protect people from the risk of abuse and knew how to escalate any safeguarding concerns. The provider had safeguarding and whistleblowing procedures in place. Staff had completed adult safeguarding training and knew how to respond to concerns.

● Staff looked after people's finances. We counted 1 person's money and saw there were effective systems and checks in place to ensure risk of financial abuse was minimised.

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 supporting people living at the service to minimise the spread of infection.

● 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 responding effectively to risks and signs of infection.

● 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.

Visiting in care homes

● People were supported to have visitors in line with current government guidance. Relatives we spoke with told us they were able to visit when they wished.

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.

Adapting service, design, decoration to meet people's needs:
- The design and decoration of the premises did not always meet people's needs. The home was in need of modernisation.
- We identified 3 leaks in bathrooms. We saw that repairs had been requested no work had been agreed. One person had a leak in their shower which meant there was a constant dripping noise, staff were not aware of this leak until it was brought to their attention by the inspector.
- In another bathroom the seal of the bathroom door was broken which meant people could not have a bath, a repair had been raised but it was still not completed.
- The walls were painted in plain colours and there were very few photographs or pictures around the building to provide a homely feel.
- The net curtains in some people's rooms were too small and in need of a wash as they had sun damage.

The failure to ensure the premises and equipment were properly maintained and suitable for the intended purpose is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed before they moved into the home. People's protected characteristics under the Equality Act (2010), such as religion and disability were considered as part of the pre-admission process.

- People and their families were involved in assessments to make sure people's needs could be met before they moved into the home. Assessments included people's religious and cultural needs which are characteristics detailed within the Equalities Act 2010

Staff support: induction, training, skills and experience
- Staff had completed training in learning disabilities or autism, which is now a legal requirement for services supporting people living with learning disabilities
- As described in the Safe section of this report, agency staff had the relevant training, however it was evident some -agency staff simply were not competent to care for people in a caring or dignified way. We observed agency staff using their phone whilst sitting or standing over people. We brought this to the attention of senior staff, and they told us they would remind staff of the phone policy.
- Staff were required to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care

sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

● People's dietary needs and nutritional requirements were assessed, and people were supported to have a balanced diet. Staff said they used the resident meeting to discuss what food people liked to eat. If people were unable to communicate verbally, staff used picture cards to enable them to choose the meals they liked.

● Staff told us they also used observation such as facial expression and eye contact where some people were unable to respond to the picture cards. A pictorial food planner was displayed in each of the dining areas as well as a daily menu offering 2 choices.

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

● The provider had plans in place to support people with complex health needs. There was evidence of prompt action taken to address health concerns. The service worked with specialist health services such as the speech and language therapists and acted on their recommendations.

● The service had good links with the local GP service. There was a structured process for handing over information of concern to health care professionals

●People's records contained a 'hospital passport'. This was a document which provided important information in the event of a hospital admission. This included the person's preferred name, GP and next-of kin details, medical history, level of comprehension and ability to consent and any distressed reactions that may cause risk.

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 and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider was working within the principles of the MCA. Where people lacked the mental capacity to make decisions about their care and were deprived of their liberty, we saw their capacity had been assessed and appropriate authorisations were sought from the local authority.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. The rating for this key question has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People received care from staff who were individually very kind and caring. It was evident staff cared about people deeply and were concerned about their welfare. Some relatives spoke positively about the staff, comments included, "The manager is extremely good, and staff are terrific, they are such lovely people" and "Everything is good, and I am happy with the care [person] receives." Other people and relatives spoke about the change in staffing and how this impacted on the day to day running of the home. This referred to the difference, quality of care and knowledge provided by permanent and agency staff.
- Staff had all completed equality and diversity training. Care plans contained sufficient detail to guide staff on people's equality and diversity needs

Supporting people to express their views and be involved in making decisions about their care

- Staff used a variety of techniques to help make sure people understood the choices being offered. It was clear some staff knew people very well, however, it was not always evident if some agency staff had the same level of understanding.
- People had an assigned member of staff (a keyworker) who met with them to discuss their care and any changes. Feedback from relatives was mixed regarding these sessions due to high turnover of staffing.
- Some people's representatives were not always made aware about changes to care, and this caused some concern as they were often told important information too late.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always promoted. Staff were repeatedly observed to stand over people when assisting them to eat and drink, instead of sitting at the same height as the person being supported. This meant the member of staff was not able to face the person and provide good eye contact.
- People and their relatives told us they were not always able to make decisions about how they spent their time, as it was dependent on staff availability and the use of agency staff.
- Notwithstanding our observations, people and their relatives spoke well about some staff and spoke how they were happy their loved ones were living there. Family members felt people were happy at the home.
- Within care plans we read how staff could support people to stay independent such as encouraging people to pick items of clothing and also encouraging people to do specific tasks of their personal care.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

● The service did not always meet people's needs and preferences. People did not always receive care that was personalised. Reviewing of care plans was inconsistent and whilst staff were signing to say they had read care plans some information was out of date and no longer relevant. For example, we read 1 person went home every Friday. We asked staff about this, and they said,"[Person] has not been home for over 2 years."

● In another person's care plan, we read a specific musical instrument was important to them, but it had broken, and staff had not been able to replace it, the persons care plan read, "What is important to [person] is a large selection of sensory toys as it relaxes [person] mind." A staff member told us they were trying to source this musical instrument. On the second day of the inspection the inspector observed this person playing with the radiator and asked staff if they had sourced this person's musical instrument. Staff told us they were not aware this person had any interest in this piece of equipment.

● People using the service and their relatives felt they were not regularly updated when changes were made to how their care was being delivered.

The lack of person-centred care plans placed people at an increased risk of not having their needs met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The support provided to people to participate in activities that were important to them was ineffective. Some staff were not aware of activities people liked to participate in. For example, 1staff member spoke about the person enjoying the water and the inspector asked if the person went swimming and were told they didn't however, within their care plan it was recorded they like to swim. We asked when the person had last gone swimming and we were told they had not swum in at least 2 years.

● In another person's care plan, we read, "Person likes a member of staff to support them to fulfil this activity regularly." We spoke with staff, and they said this person didn't swim as they needed a specific card at the swimming pool. Again, staff spoke about simply not having the time or the resources to complete this task which should be relatively straight forward.

● All of the people enjoyed music, and this was central to their care plans however the majority of people were not supported to participate in this activity. Staff said people went to activities before COVID -19 but not any longer and staff were not familiar about musical activities that were available to people living in the area. Care staff were also responsible for leading on activities and they simply did not have time as they also

had other responsibilities such as logging building repair issues and chasing up maintenance teams.
● One person enjoyed music and they had music equipment in their room. We asked staff why the person had their music instrument turned off at the plug and we were told, "Person brings over the chair and sits when they want to play music." There was no chair suitable for the person to use for playing music.
● Staff spoke with passion about wanting a space within the home for a dedicated sensory room as they believed this would benefit people greatly, they were constantly met with barriers and no solutions from senior managers. This was also confirmed by relatives who told us staff were discussing this sensory room for over 2 years.
● People told us they would like to attend more activities such as watching football games and go on more outings, but this simply wasn't a priority. One relative told us the home was, "Soulless and, limited activities happened especially at the weekend."

This placed people at an increased risk of not having their needs met. This was a further breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notwithstanding the above, on the day of the inspection 6 people had gone on holidays and the provider was planning to take the other 6 people later in the month.
●Some family members also spoke positively about the activities, 1 relative said, "Yes, there are regular outings and events [Person's] keyworker is terrific at arranging outings."
● People did go on activities such as sailing and walks to the park and the local pub however it was not always clear if these were activities people enjoyed or simply activities staff could manage because of the issues they were having with permanent staff.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● The provider was not meeting the AIS. Documents about people were not provided in a format they could understand. There were not simplified versions of people's care plans or options to provide this in large print or pictorial versions as necessary.

This placed people at an increased risk of not having their needs met. This was a further breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
●There was a complaints policy and procedures and there had been no recent complaints. We noted in people's room, there was A4 sheet about how to make a complaint. This was not in easy read format and people would struggle to be able to read the font as it was so small. Senior staff told us they would ensure the complaints procedure was accessible.

End of life care and support
● People had plans in place to describe their end of life needs and wishes. Senior staff said this was a discussed with people and their relatives.

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

- The provider did not have effective quality assurance checks in place to ensure people were receiving good care and support. For example, building repairs had been logged by staff but it took significant time for repairs to be completed and the majority of the time they were not fixed to a satisfactory standard. For example, a broken shower head was replaced however it was too small to be used correctly which meant staff could not wash people's hair.
- We could see the registered manager had carried out regular audits in the home including health and safety and care plans. However, our findings showed audits were not always effective because they had failed to identify the issues we found during our inspection in relation to care planning and meeting the needs of people.
- A lack of good governance and effective management meant there was no evidence of learning. Incidents had not been investigated adequately to explore where improvements could be made.
- We reviewed the home's action plan, and we could see it took a significant amount of time for actions to be resolved. For example, staff raised a need for a carpet to be replaced in a person's room due to a strong mal odour. The concern was highlighted in July 2022, and it was resolved at the end of March 2023.
- Some staff morale was low as staff were frustrated with the lack of action when concerns were highlighted. One person had a specific piece of equipment which they enjoyed using which was broken since July 2022. A staff member was trying to get this repaired but through no fault of their own simply could not progress the repair as it needed financial procedures put in place from the provider.

This shows systems were either not in place or robust enough to demonstrate the quality and safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Following the inspection feedback the provider sent us an action plan to address the concerns raised.

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

- There were not suitable arrangements in place for gathering people's and relatives' views about the quality of service provided. There was mixed feedback from relatives about not being kept informed about people's needs. 2 family members spoke about not always being kept informed about activities and important events. One family member was frustrated about the lack of information given when trying to

organise family events for people living at the home.
● People were not always supported in an empowering way to enable them to have choice and be supported in a caring way, for example, we read in a residents meeting how 1 person wanted to do a specific activity. This was recorded but had never happened.
● The permanent staff we spoke with demonstrated they were passionate about the people they cared for. A staff member told us they, "Worked here because the people they cared for were like family to them."
● We could see evidence of regular team meetings, but they focused on issues such as health and safety and it was clear staff had frustrations which could have been resolved if the provider took prompt action to address the issues with the building and the urgent repairs.

The provider failed to ensure effective systems and processes were in place to assure them-selves of the quality of service and care being provided. This was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff we spoke with gave us varying feedback about the day to day running of the home. Some staff were honest about the challenges they faced due to the repairs and staffing issues, but some staff told us they had no concerns, and they believed the care people received was appropriate to their needs.

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
● As part of the inspection we spoke with the area manager about their understanding of their responsibilities under the duty of candour and they demonstrated they understood their responsibilities. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.
● It was evident there was an element of inertia when the inspector raised issues with the senior manager. They spoke about the frustration they had with the repairs and the maintenance team but failed to understand the impact living with these outstanding issues had on the quality-of-care people received. This was further highlighted when we spoke with a professional who discussed the lack of understanding by the provider and the impact on people and staff on having to wait for issues to be resolved at the home.

Continuous learning and improving care
● The provider was not learning from previous incidents. We identified repairs which had not been logged and were brought to the attention of staff by the lead inspector. When we visited the home on the second day, we found repairs were still outstanding and areas of concerns had not been addressed.

Working in partnership with others
●The staff worked closely with other healthcare professionals to make sure people's health needs were assessed, monitored and met. Senior staff did not always have the time to develop partnerships within the community to increase the opportunities for people to participate in activities. Staff spoke about partnerships which were dissolved after COVID-19 and they would welcome the time to be able to go and meet new services within the locality.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure service users received care which met their needs and preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensure safe care and treatment because they had not always assessed risks to service users safety nor had they done all that was reasonably practicable to mitigate the risks to the safety of service users. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not always ensure that the premises and equipment that is used to deliver care and treatment was maintained properly. Regulation 15 (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

The provider was not always operating effective systems and processes to assess, monitor and improve the quality and safety of the service and
to assess, monitor and mitigate risks.
Regulation 17(1)