Achieve Together Limited

Highbury House

Inspection report

36 Aston Road
Wem
Shrewsbury
Shropshire
SY4 5BA

Tel: 01372364077

Date of inspection visit:
19 July 2023
21 July 2023
25 July 2023

Date of publication:
24 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
Highbury House is a residential care home providing personal care to up to 11 people. The service provides support to adults with learning disabilities and autism. At the time of our inspection there were 10 people using the service. Highbury House consists of 3 neighbouring properties. People have their own bedroom with ensuite facilities and access to shared communal space. The home is situated close to local amenities.

People's experience of using this service and what we found
At our last inspection, we found concerns related to staffing and management oversight of the service. These concerns resulted in regulatory breaches. In response to our last inspection the provider sent us an action plan telling us how they were going to make the required improvements.

At this inspection, there continued to be a lack of effective oversight to ensure standards and regulations were maintained. Some areas previously identified as a concern, remained. We also identified additional breaches of the regulations. Examples of audits were either not completed or they were ineffective when completed, in identifying where improvement was needed. Several improvement actions we found during our visit had not been identified through any provider checks at the service. Issues with staffing identified at the last inspection remained.

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 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.

The evidence to confirm people's restrictions had been imposed in their best interests could not be located and a number of Deprivation of Liberty Safeguards (DoLS) authorisations had been allowed to expire. Staff involved people in making day to day decisions. However, people's ability to decide was often limited, due to the staff and resources available. People were supported at mealtimes and guidance was in place around healthy eating. However unfamiliar staff and reduced food supplies impacted people's choices.

The home was clean and areas which had become worn were highlighted for refurbishment. People were able to access healthcare when needed and appointments were made when they felt unwell. However, improved record keeping following a health emergency was needed.

People received their medicines by staff trained to administer. However, improved guidance was needed on

why people took certain medicines because the current guidance was not always person centred.

People could personalise their bedrooms and refurbishment work was ongoing throughout the properties.

Right Care: People were not always protected from the risk of harm as accident and incident forms were not reviewed in a timely manner. Actions taken to mitigate the risk of harm could not always be evidenced both in the environment and in the care people received.

People's care plans were detailed however updates were required. Some updates identified at our last inspection had not been actioned. For example, the physical intervention training being used had changed but the care plans still referenced historic training.

Right Culture: The culture in the home was not always person centred. Staff felt the volume of management changes had impacted and improved relationships were needed. People were not always supported by sufficient staff who knew them well. Agency staff were used but a recent change in provider meant there had been a reduction in the consistency of the support provided. Staff received training and this was monitored closely by the local authority. A recruitment strategy was in place.

The governance systems used were not always effective. Key reviews were not always happening, and it was difficult to access information to confirm the frequency of health and safety checks and action taken. The process to continuously learn and improve care was limited due to the providers systems not being fully embedded.

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

Rating at last inspection
The last rating for this service was requires improvement (published 19 August 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and the management of risk in the service. 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 requires improvement to inadequate based on the findings of this inspection. 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 inspection, by selecting the 'all reports' link for Highbury House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the management of risk in the service and how people are safeguarded from potential abuse. We found people were subject to restrictions. However, we could not be assured these were agreed in people's best interest. We found a continuous breach around the governance of the service. Systems and processes were not embedded, and highlighted improvements had not been made between this inspection and the previous one.

The provider was asked to submit an urgent action plan in relation to key areas following the inspection visit.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Highbury House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
This inspection was carried out by 2 inspectors.

Service and service type
Highbury House 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. Highbury House 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 not a registered manager in post. A new manager had recently been appointed and they were in the process of applying for their registration.

Notice of inspection
This inspection was unannounced.

What we did before 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
During the inspection we spoke with 3 people who use the service and 14 staff members including a head of operations, regional manager, manager, deputy manager and support workers. We spoke with 2 relatives. We looked at 4 care files and multiple medicine records. We looked at 3 staff files and the training records for all staff. We looked at health and safety documentation, accident and incident forms and other information relevant to the day-to-day management of the service. We observed the care and support people received over the duration of the inspection.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection, we found staffing numbers and suitability of staff did not provide appropriate support to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and there was a continued breach of regulation 18

Staffing and recruitment

- At the last inspection we raised concerns about the staffing levels and at this inspection we found the concerns continued. The records in the service reflected that despite there being a safe staffing level risk assessment in place, there were times when this was not maintained. This impacted people as it meant there were times when some individual's needs had to be prioritised and this limited other people's access to meaningful activity.
- Staff told us they did not always feel safe in the service, especially when the staffing level was below expectation, and they needed to work alongside high numbers of agency staff. One staff member told us, "I do love my job, but I am exhausted. I never know who I am working with and whether people will be able to get out." Another staff member said, "We are a good team but it's hard when you work with too many agency staff. We used to be sent regular agency staff so it was easier, but we are back to square one since the agency changed. Some are excellent but they don't all have the same skills. Sometimes we don't have enough medicine trained or behaviour trained staff so that puts pressure on the rest of us to cover everything."
- People were also frustrated by the lack of regular staff. We observed 1 person speaking with staff on 2 separate occasions trying to arrange activities for themselves and establish whether they would have regular staff or agency staff on a given day to support them. When we asked people, they confirmed the staffing situation was frustrating and they would like more consistent staff.
- The staffing numbers and people's ability to access the community was a concern for some families. One relative told us, "They used to do loads of community activities but since covid nothing seems to have restarted, it must be so boring at times."

There were insufficient numbers of suitably qualified and experienced staff being deployed to meet people's needs and mitigate any potential harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider shared with us their recruitment strategy to increase the numbers of permanent staff employed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● We could not be assured that people were protected from the risk of abuse or that lessons were learnt when things went wrong. Robust procedures were not in place to ensure concerns were identified and acted upon in a timely manner.
● Staff completed accident and incident forms when things went wrong. However, the provider had not yet reviewed all the completed forms. We found there was a backlog of reports still requiring management attention.
● We found some outstanding reports referenced bruising and the root cause was yet to be established. The lack of review meant the provider could not be confident people were not being exposed to ongoing harm either by accident or due to deliberate actions.
● Before the inspection we had identified a number of safeguarding concerns which had not been shared with us, which is a legal requirement. However, at the time of our inspection we were reassured these had been shared with the local authority. Due to the backlog of reports we could not be assured that the local authority had been alerted to all concerns for them to be enabled to carry out their legislative duties.
● We reviewed instances where safeguarding investigations had been carried out to see if the actions we had been advised of, had been completed. We found 1 person still waiting for their positive behaviour plan to be updated following an incident a few months earlier. Despite the provider telling us they would do this, we highlighted on both day 1 and day 3 of the inspection visit that this still needed doing to ensure the person would be supported correctly during a crisis situation.

Robust procedures were not in place to ensure potential abuse was investigated and responded to in a timely manner. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The regular staff on duty had been trained to recognise and report abuse. They told us they would be confident speaking up to either the provider or CQC should they have any concerns people were being harmed.

Assessing risk, safety monitoring and management
● Risks within the service were not being safely managed. We found safety audits and checks were carried out, but the provider was unable to evidence whether any required recommendations had been completed. At the last inspection we reviewed the fire risk assessment but could not confirm if the identified actions had been resolved. At this inspection we found the same concerns and again we were not given evidence to confirm work had been completed other than what we could physically see.
● The provider could not evidence health and safety checks were being carried out on a regular basis. After the last inspection the provider had implemented a new computerised health and safety system and checks were being completed on the new system. However, the management team were unable to extract information to allow us to establish how often health and safety checks were completed to ensure people's continued safety. This included water temperature checks and infection control audits.
● Risk assessments were not always completed or reviewed after a serious incident to ensure the most effective and proportionate action was taken. This meant people and staff were at risk of incidents being repeated due to a lack of consideration. We found 1 incident of significant concern had been closed but required an urgent risk assessment to be completed. We asked the provider to take urgent action.
● The service had not updated care plans to reflect the change in behaviour management training being used. This was despite telling us at the last inspection this work was almost completed. Incorrect information was a concern for all staff, especially new staff who read people's care plans to help them understand the risks they may face and how to support people safely.

The new systems had not been implemented sufficiently to ensure health and safety risks were being mitigated. This placed people at risk of potential harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Guidance was in place to support staff to administer people's medicines. However, we found clarity was needed when people had different medicines for similar health needs. For example, we found 1 person had the same protocol in place for 2 different pain relief medicines. We discussed the need to ensure staff knew when to give 1 medicine instead of another.

● Staff could access a detailed list of what medicines people took, why they were prescribed and what outcome was expected. But for some medicines we found the language was not person centred. For example, records suggested people took certain psychiatric medicines due to behaviour's associated with having learning disabilities. This is misleading and does not explain why an individual had been prescribed a specific medicine.

● A process was in place to review medicine errors, but we were not assured that all errors had been reviewed and action taken to mitigate any future risk. We also queried the number of medicines trained staff and were told further training had been scheduled to increase the number of staff with this skill set.

Preventing and controlling infection

● We were somewhat assured that the provider was responding effectively to risks and signs of infection. Audits were completed but we could not establish the level of frequency of such checks or what actions were taken.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas needed further cleaning and we were made aware further refurbishment was planned.

● 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 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 able to receive visitors. However, we were advised most people preferred to meet friends and family in the community or visit the family home.

Requires Improvement

Is the service effective?

Our findings

Our findings - Is the service effective? = Requires Improvement

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 requires improvement. At this inspection the rating for this key question has remained 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, and whether any conditions relating to those authorisations were being met.

- At this inspection we found the provider had not been monitoring people's DoLS authorisations and several had been allowed to expire.
- We reviewed the restrictive practice checklist the service used to monitor the restrictions people did or did not need. The current management team could not locate the evidence confirming the agreed restrictions had been considered under the MCA and they were agreed in people's best interests. Without seeing the documentation, we could not be reassured the principals of the MCA were being adopted and that all restrictions were lawful.
- Some people could require low level restraint during times of crisis. However, due to inaccuracies in care plans and the need for positive behaviour plans to be updated we could not be sure the least restrictive practice was being adopted.

People were subject to restrictions which could not be evidenced to be in their best interests. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider informed us they had submitted updated DoLS applications to the local authority.

● Staff were seen supporting people to make day to day decisions. For example, deciding where they wanted to go in the community.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink throughout the day. The new manager told us they were reviewing the menus to ensure people were getting a balanced diet.
● People had access to food and drink at all times. However, staff did tell us the food supplies at times ran low meaning people did not always have access to the choices they wanted. We asked the provider to review this situation.
● Staff knew how people liked their food prepared and guidance was in place to support people to avoid excessive eating and drinking. One staff member told us, "We have plans in place to support people around food and drink. It can be awkward when we have new staff who don't follow the plans as then, people may over eat but we do try and monitor."

Supporting people to live healthier lives, access healthcare services and support
● People were supported to have their health needs met but, in some areas, improvements were needed. For example, we found 1 person's care plan stated staff could cut people's toenails which was not in line with best practice. We also spoke with another person's relative who advised their relative usually went to see a chiropodist, but they didn't think this had happened for some time. As a result, we asked the provider to review everyone's nail care needs and ensure appropriate appointments were made.
● We reviewed 1 set of records for a person who had injured their leg and discussed how the recording of information had made it difficult to see what action had been taken during a 10-day period. We were reassured to find medical professionals had been contacted but it took some time to establish this and it raised concerns that staff did not have easy access to agreed treatment plans.
● People were supported to visit healthcare professionals when unwell. We saw staff monitored 1 person's general health and supported them to access the GP when needed.
● People had health action plans and hospital passports in place to support them to be better understood when accessing health care settings.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed, and care plans were in place, but it was evident that reviews and updates were required to ensure the information was accurate. This issue was raised at the previous inspection.
● We found the management team were aware of the inconsistencies but were not addressing these as a priority. This was a concern due to the high number of agency staff using people's care plans to inform their induction. For example, PBS (positive behaviour support) plans and nail care.
● Staff had a good understanding of people's needs and the goals people wanted to achieve but told us it continued to be difficult to work towards any specific goals. This was due to the staffing situation and people not always getting consistent care. The new manager told us they had plans to address this and everyone's care plans were being reviewed.

Staff support: induction, training, skills and experience
● Prior to the inspection we were aware the local authority had been monitoring the staff training due to concerns staff were not all up to date with their mandatory training. We reviewed the training data and found there were gaps especially in relation to rescue medicines. We discussed this with the provider and were advised courses were currently running and additional courses were being booked to bring all staff up to date.
● Some staff told us they did not like the online training and wanted more face-to-face training. The manager told us they were setting up a training area in the main office to ensure staff were supported with

online courses and more face to face training was being booked.
● Staff supervision records showed these had not been happening in line with the providers policy. We saw plans were in place to increase the supervisions staff received.

Staff working with other agencies to provide consistent, effective, timely care
● The provider did engage with other agencies, and we were advised health colleagues had recently visited to review and support some individuals whose behaviour required additional attention.
● Relatives and staff advised opportunities were reduced during the pandemic and effort was needed to establish relationships with other agencies. One staff member said, "We used to link in with the community and other groups a lot more and I hope we can get back there again as it was good."

Adapting service, design, decoration to meet people's needs
● The 3 properties at Highbury House had undergone some refurbishment and further work was planned. Some of the bathrooms had been refitted and new furniture had been purchased.
● Some people's bedrooms had been redecorated and were personalised to people's individual taste. Other people were waiting for work to start on their bedroom. One relative told us, "My [relative's name] really wants to improve their bedroom and they have the money to buy some furniture for themselves, they just need the home to facilitate."
● We discussed communal areas and the garden area with staff. They told us they had ideas to make the spaces more useable, especially the back garden.

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 requires improvement. At this inspection the rating had changed to inadequate. This meant there were significant shortfalls in the management of the service. Leaders and the culture they created did not assure the delivery of high quality care.

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

At this inspection not enough improvement had been made and the provider remained in breach of regulation 17.

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

- The governance systems in place continued to be ineffective. Issues found at the last inspection remained and further issues were identified as requiring attention. The providers systems and processes were not robust, effective or embedded, with a lack of oversight that failed to identify significant gaps in the quality of the service people received.
- The provider had not submitted notifications in line with regulations. This issue was identified prior to the inspection and remained unresolved. We understood there had been some management changes which had a negative impact on the service. For example, the significant back log of accident and incidents requiring review. Systems and processes failed to offer assurance the provider knew of cases of potential harm, be that accidental or deliberate. Those systems failed to record if appropriate actions had been taken to keep people and staff safe or whether the action taken was proportionate to the circumstances.
- When reviewing the environment, we could not be assured all areas were compliant with the Health and Safety regulations. This was because the evidence was not made accessible to us. We knew checks were happening, but the provider failed to demonstrate the frequency of the checks or if actions had been completed. At the last inspection, we were given assurances by the provider actions from the fire risk assessment carried out in February 2021 were being addressed. At this inspection there was no evidence provided to us to confirm this had taken place.

The governance processes in place remained ineffective and risks to people and staff were not being mitigated. This was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the level of concern found on this inspection the provider was asked to submit an urgent action plan to outline how and when they would address the shortfalls. This action plan has been received and reviewed.

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

● The culture in the home was not person centred. Some people had had positive experiences in the past year. They had been on holiday and developed new relationships. However, some people remained limited in what they could do due to the staffing situation and behaviours of others. This was despite 1:1 funding being in place.

● Staff engaged positively with the inspection process and the majority of staff told us they felt there was a divide between the staff team and the provider which was impacting on their wellbeing and affecting the outcomes for some people.

● One staff member said, "We are all committed which is why we are still here, and we know it will improve but management need to work with us and listen to what we know works and doesn't work. Sometimes they expect us to do too much and when staffing is low this can affect people's behaviour which puts us at increased risk. This makes me anxious."

● We shared the concerns with the management team who said they would be increasing their engagement with staff and ensuring adequate support was in place.

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 provider was aware of their duty of candour but we do not know it if was always being applied due to identifying an issue with the sharing of information.

● We did observe 1 person had injured themselves and we were reassured to observe a conversation between the family and the manager. However, the root cause of the injury continued to be explored.

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

● Staff received a recent supervision and attended team meetings. However, when we checked the records, we found they had only recently recommenced after a period of inactivity.

● All staff reported frustration with how the service was performing and wanted better engagement with the management team. A number reported feeling their views were not being respected when they knew people in the service better and knew how things worked.

● Community engagement decreased during the COVID-19 pandemic and had not been fully recommenced. One staff member told us, "We do visit some places, but it does feel like we have become more isolated as a service. We do not seem to mix with other services as much as we used to."

● Relatives supported this view telling us a number of activities had stopped in recent years and they did not know when they would be restarted and/or replaced with something of equal importance.

Continuous learning and improving care

● Since the last inspection the provider had failed to ensure the service had improved. At this inspection we found similar concerns to our last visit, as well as new concerns with limited action being taken to address these shortfalls.

● Investigations were completed when something happened. However, these were not always robust and did not always consider all mitigating factors. For example, whether staff were working in line with the guidance in place or having to adapt their practice to reflect internal pressures, such as, limited permanent staff on shift. One staff member told us, "We really try our best, but we don't always get listened to when we suggest how we can make things easier for everyone. For example, the money is now in the main house which is a nightmare for us when staff is limited, as it takes twice as much time to get out the house which can then upset people."

Working in partnership with others

- The provider did work with others. However, the Local Authority reported information was not always forthcoming.

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 MCA assessments and best interest decisions were not always considered, completed or available to support the restrictions people experienced.

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 adequately manage risks within the service and could not evidence that all reasonable steps were taken to ensure people's safety.

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 Robust procedures were not in place to ensure all incidents were reviewed, appropriate referrals were made and action was taken to mitigate the risk of future harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust quality systems or processes were fully effective to monitor the service appropriately, including people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Safe staffing numbers were not always available and the high use of agency staff affected the consistency of support people received.