Heath House Project Ltd

Heath House

Inspection report

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Date of inspection visit:
09 May 2023
11 May 2023

Date of publication:
28 June 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Heath House is a residential care home providing personal care to up to 17 people. At the time of the inspection the service was providing support to people living with dementia and people experiencing poor mental health. At the time of our inspection there were 9 people living in the service, 8 of whom were receiving the regulated activity of accommodation for persons who require nursing or personal care.

Heath House consisted of 17 one-bedroom flats, which included a living area, kitchen, and shower room. There was a small communal lounge and dining room.

People's experience of using this service and what we found

People were not safe living in the service. Individual risks to people and environmental risks had not been assessed and responded to. Infection control risks had not been adequately responded to. Medicines were not handled or stored safely. People did not always receive their medicines as prescribed. Staff had not received training in responding to safeguarding concerns. No system was in place to ensure safeguarding concerns were reported and investigated as required. People told us they did not feel safe living in the service. People and relatives raised concerns about the high turnover of staff and high use of agency. Staff were not effectively deployed.

People were supported by staff who had not received adequate training and support to carry out their roles and meet people's needs safely. The physical design and service environment had not been adapted to meet the needs of the people living in the service. This had resulted in people's needs not being met. People and relatives raised concerns about the quality of the food provided. People's preferences and input had not been used to help ensure the meals provided were suitable. Staff were not proactive in seeking input from health professionals. People's health needs were not met and recommendations from health professionals were not always followed. CCTV was being used in internal areas but people's consent to be recorded had not been sought.

People were not treated with respect and their dignity was not upheld. Staff had failed to consider how to support people's independence as a result people's dignity had been compromised. People and their relatives were not involved in the support provided. Their views, opinions, and preferences were not sought. The lack of engagement and involvement of people and their relatives had resulted in people's needs not being met.

People did not receive person-centred care. People's care plans contained limited information on their needs and preferences. People told us there was not enough social activities and entertainment. People's communication needs were not always supported. Robust responses to concerns and complaints had not been made.

No governance frameworks or systems were in place. This meant the quality of the service and any potential risks had not been effectively assessed or monitored. The service had started providing the regulated activity in February 2023, since that date there had been 3 different managers in post. The provider had failed to put in place effective systems to maintain oversight and information within the service. This had resulted in the current manager having limited information and no systems to ensure a safe and good quality service. Records had not been sufficiently maintained. Effective actions to improve the quality of the service had not been taken. People, relatives, and staff had not been fully involved in the support provided. Their feedback had not been sought. People and relatives told us communication was poor. The provider worked with local authority and health care staff during the inspection to address the most serious concerns identified and ensure people's safety.

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

Rating at last inspection
This service was registered with us on 25 October 2022 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about medicines management, staff training, management of risks to people, and governance.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing, the premises, consent to care, dignity and respect, person-centred care, and good governance at this inspection. We imposed urgent conditions on the provider's registration as a result.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Heath 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
The inspection was carried out by 2 inspectors and a medicines inspector.

Service and service type
Heath 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. Heath 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since it had been registered. We spoke with professionals from the local authority and integrated care board who had recently visited the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people using the service and 4 relatives. We spoke with 7 staff, this included 2 care assistants, 2 agency staff, the manager, a company director, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed the care being provided, this included over lunchtime and medicines administration. We reviewed 9 medicine administration records (MARs) and the care records relating to 8 people's care.

Inadequate

Is the service safe?

Our findings

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

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

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

- The inspection found significant concerns regarding the management of individual risks to people. We identified people were at risk in areas such as skin integrity, choking, malnutrition, and distressed behaviours. However, the management team were unable to demonstrate that these risks had been robustly assessed and that sufficient action to address these risks had been taken. This had put people at risk of harm.
- In some cases, we identified significant risk from reviewing people's daily notes which had not been identified and which the management team were not aware of. For example, within daily notes we found it was recorded one person had experienced several incidents of distress and been at risk of harm during these. The manager told us they were unaware of these incidents and no action had been taken to consider how this risk could be reduced.
- No system was in place to ensure incidents were recorded and reported. This meant potential risk was not being identified and could not be responded to.
- Environmental risks had not been robustly assessed. We identified significant concerns in a wide range of areas relating to the environment. For example, one person required equipment to evacuate in the event of a fire, but this equipment had not been provided. Actions to monitor and manage the safety of the water, such as in relation to legionella bacteria had not been taken.
- The security of the premises had not been considered in relation to people's safety. An incident had occurred when one person, who was at risk on their own in the community, was found on their own outside the building but no review of the safety of the building had been taken. We found exit doors unsecured along with garden gates that meant people could exit the building via a steep ramp on to a busy road. Several people living in the service experienced confusion, disorientation and were at risk should they leave the building on their own.

Actions to mitigate risks of harm to people were not effective. Not all risks to people had been assessed and considered. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

- Laundry facilities and arrangements within the home were not suitable and did not consider infection control risks. For example, people's clothing and bedding, including soiled items, were being washed within people's flats in domestic washing machines.
- No drying facilities were in place which meant people's clothing was being dried by draping items over doors and kitchen units and other surfaces in people's flats. A relative told us when they visited, they found staff were, "just laying wet clothes everywhere."

● In one person's flat we found soiled items in a kitchen cupboard with a biscuit on top. In another person's flat we found large drops of blood left on their floor. This posed an infection control risk.
● We were concerned personal protective equipment (PPE) was not always being disposed of safely. This was because we observed discarded PPE in the grounds below a window.
● We found bins in the service for offensive waste, such as continence products, did not have lids on. We observed the external large waste container for offensive waste was overfilled, the lid could not be shut, and bags of waste were placed next to it. We asked the manager about this. They told us the waste storage facilities were not sufficient for the waste being generated.

Effective actions had not been taken to prevent and control the risk of infection. 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
● Medicines were not stored safely. Staff had not recorded the room and fridge temperatures where medicines were stored since the first week of April. During the inspection the room temperature exceeded 25 degrees. This is the maximum temperature recommended by manufacturers for most medicines. This meant that the service could not be assured that medicines were always safe to use.
● People did not always receive their prescribed medicines. For example, we saw one person had received an incorrect dose of their antipsychotic medicine and missed this medicine on two further occasions. Staff told us that this medicine was unavailable, but we saw that a full box was available. This placed this person at risk of worsening this condition.
● One person had been prescribed an antifungal cream, however, there were no records of application or body map available to guide staff when applying this cream. This meant that the person may not have received their cream as prescribed leading to worsening of their skin condition.
● People who were prescribed topical emollients did not have guidance for staff of where to apply the cream. Additionally, there were no records of application available. This meant we could not be assured people were receiving these medicines as prescribed.
● Protocols to provide guidance for staff on when to administer when required (PRN) medicines were not person specific and did not provide sufficient information. Staff did not record the time, reason, or outcome for the person when they administered these medicines. This meant the effectiveness of the medicine could not always be reviewed.
● Care plans did not have guidance for staff on how monitor and identify side effects and effectiveness of medicines. Staff we spoke to were unaware of some of the complications to look out for in high-risk medicines such as blood thinners or immunosuppressants.

Medicines were not safely managed, and people did not always receive medicines as prescribed. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The management team were unable to demonstrate that staff had received training in adult safeguarding and understood their responsibilities.
● The absence of an incident reporting system and a lack of oversight of the care meant safeguarding concerns would not be identified and reported for investigation as required.
● There had been a lack of clarity on the type of needs the service could support. People had come to live at the service without proper consideration of those already living in the service and any conflicting needs or risks. This had resulted in people living at the service with a wide range of needs which had a times created conflict.

● People told us this had resulted in them feeling unsafe. One person said, "It's awful. It was ok but I think they couldn't get any one in and then they took anyone". They went on to say, "It's a total wrong mix."

Staffing and recruitment

● Whilst we observed sufficient staff to meet people's needs, we did not find them to be effectively deployed. We observed staff sitting around chatting to each other and there was no clear direction provided. A relative told us, "All I've seen them [staff] doing is sitting about."

● We identified concerns with the retention of staff. During our inspection several staff, including the manager ceased working in the service. Following our inspection visits staff numbers had reduced to 3 staff.

● This meant there was a high reliance on agency staff within the service. This was a concern given the lack of clarity on people's care needs, the lack of management oversight, and the lack of systems within the service.

● Whilst most safe recruitment practices had been followed, we found a member of the previous management team had provided references themselves for the staff they had recruited. No further consideration of other sources for character references had been considered.

Visiting in care homes

● No restrictions on visits were in place. We observed relatives freely visiting and spending time in the service.

Inadequate

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- The management team were unable to provide any evidence that staff had received any training and that their competency had been assessed. This included staff who administered and handled medicines.
- We identified concerns about staff competency and understanding in a range of areas. This included medicines management, dementia support, mental health support, pressure care, and continence care.
- Systems to verify agency staff had the training and competency in areas required were not robust. For example, agency staff were providing care and support to two people with a diagnosis of epilepsy. The management team had not checked that these staff had been trained in epilepsy management and knew what to do in the event of a seizure.

The provider had failed to ensure staff were suitability skilled and competent to deliver care and support to people living in the service. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The premises had previously been designed to provide "retirement living" with self-contained flats. At the time of the inspection no consideration had been given for how people and any visitors would enter or exit the building. Visiting health professionals raised concerns about access to the service due to this. There was no system to alert staff on arrival. Individual flat doorbells were in place however most people would not have been able to answer them.
- The entry and exit system also raised concerns about how secure the building was and its suitability for the people living there. Some people were at risk should they exit the building on their own but at the time of the inspection no adaptations had been made to ensure their safety.
- People and relatives told us they did not feel the physical environment was suitable as a care home. A number of relatives and professionals raised concerns about the size of the service and the car park, which only accommodated 3 cars. A relative told us, "The lounge if 2 or 3 people had visitors you couldn't even get in there."
- The provider had failed to consider the design of the service against people's specific needs and conditions. The seating in place was very low and we observed people struggling to get up from these seats. Relatives also raised concerns about the seating provided and told us they had also observed the seating levels causing their family members problems.
- Several people living in the service were living with dementia. Despite this no suitable dementia signage was in place, such as on their flat doors, to help them navigate around the home. One person had been experiencing episodes of distress and accidently locking themselves in their flat. No action had been taken

to review their environment and make adaptations.
● Some of the flats were extremely dark with limited natural lighting. This was a particular concern for people who were at a higher risk of falls or with visual impairments. No assessments to check the suitability for people in terms of which flat would meet their needs were in place.
● Some people living in the service chose to smoke cigarettes. However, no suitable smoking facilities, such as a smoking shelter, had been provided. We observed an empty coffee container was being used as an ashtray.

The provider had failed to ensure the premises and equipment was suitable for the purpose for which they are being used. This was 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; Supporting people to eat and drink enough to maintain a balanced diet
● Holistic assessments of people's needs and preferences had not been carried out. The manager advised us not all people living in the service had had their needs assessed.
● Where people's needs had been assessed there was insufficient detail to ensure people were receiving the care and support they required.
● People had not been asked their preferences in terms of meals. Their likes and dislikes were not used to inform meal planning. We observed one person's expressed preferences around food was not fully observed and they were not given a choice as to which meal they would have preferred.
● People and relatives raised concerns about the quality of the food on offer. One person told us, "Don't think much of it." Whilst a relative said, "Quality of the food was not great on 2/3 occasions I saw [family member] being given mashed potatoes and baked beans. A second relative told us, "Basic that's all I can say really, all frozen stuff."

The provider had failed to ensure people's needs and preferences were considered to ensure people received person-centred care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We found staff were not proactive in identifying and raising health concerns with relevant professionals. This had resulted in a lack of clarity around how staff were supporting people's health conditions and any associated risks.
● One person was using the incorrect continence products which was causing them significant discomfort. The manager was not aware of this and was not able to demonstrate a referral for health care support had been made.
● For another person we found staff had not implemented and followed recommendations from a health professional on how to support the person when distressed. A relative told us how staff had failed to respond to concerns raised about their family member's health.
● People's care plans did not contain sufficient guidance for staff on how to support individual health conditions, such as dementia or epilepsy.

The provider had failed to ensure people's needs and preferences were considered to ensure people received person-centred care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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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

● People's capacity and their ability to consent to aspects of their care had not been considered. CCTV was in use within the service but no consultation on its use or consent had been obtained from the people living there.
● Whilst DoLS requirements had been assessed and applied for, we found the service had not followed the code of practice. This was because no consultation and involvement of people's relatives had taken place.

People's consent and their capacity to do so had not been sought. DoLS applications had not been made in accordance with the MCA. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People's dignity was not upheld. The lack of care in relation to people's belongings demonstrated a lack of respect. Relatives told us they were unhappy about how their family member's items were cared for. One relative told us they had paid out additional money to replace lost items.
- People were not treated respectfully. We found one person was lying on a mattress with the sheet unsecured on the bed, this had exposed the fact the mattress was still covered in plastic sheeting that new mattresses are delivered in. Another person had been living at the service for 6 weeks without a toothbrush or hairbrush. Staff had not taken action to ensure this person had the items needed to uphold their dignity and support their independence.
- Staff had failed to respond to and address situations which increased the risk of people becoming distressed and uncomfortable. For example, we saw poor support of one person over the lunch time meal which resulted in their distress escalating.
- People's independence had not been assessed and supported. One person told us how they had previously been able to manage their continence needs independently but they did not have the right equipment or support to continue this. A relative for another person told us their family member had never had incontinence issues prior to living at the service but the lack of support meant this was no longer the case. A second relative said, when asked about supporting independence, "[Family member was] just plonked in an armchair and that's where they stayed all day."

The provider had failed to ensure people were treated with dignity and respect. People's independence was not supported. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- No systems or processes were in place to support people and their relatives to be involved in their care and make decisions.
- Care plans and records did not show that these were reviewed and discussed with people and their relatives.
- People and relatives told us they were not asked for their opinions on the support provided. Several relatives told us the communication was poor.
- The lack of engagement and involvement of people and their relatives had resulted in people's needs not being met.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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; 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; 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.

● People did not receive person-centred care. People and relatives told us they were not consulted on their wishes, preferences, and needs in relation to the care they received. The management team were unable to provide evidence of any systems used to seek people's involvement and opinion on their care.
● People's care plans contained limited information on their needs, preferences, and social histories. One person had no care plans. We were not confident, from speaking to staff and our observations of the support provided, that people's needs were well understood.
● People were not supported to engage in activities they liked. There was no activities or entertainment schedule in place. People told us they were bored. One person said, "Really not enough to do. All I'm doing is sitting listening to music. You can't do that all the time."
● Whilst some people's communication needs had been considered, this had not been used to inform the support provided. For example, no written menus or pictorial menus were on display. There was not adequate signage for people living at the service who could become disorientated in time and place.

The provider had failed to ensure people's needs and preferences were considered to ensure people received person-centred care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● We reviewed one complaint which had been received and the response from the management team. This did not evidence all the issues raised had been fully considered and responded to.
● A relative told us they had raised concerns regarding the care provided with the previous manager. There was no record of these concerns. The relative told us they had been told, "If you don't like it find somewhere else."

End of life care and support

- At the time of the inspection no one living in the service required end of life care and support.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in 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; Continuous learning and improving care

- No governance frameworks or systems were in place. This was across a wide range of areas. For example, no audits were completed on the support provided, no staffing tool to assess safe staffing levels, no staff handover system, and no incident reporting and assessing systems were in place. This meant the quality of the service and any potential risks had not been effectively assessed or monitored.
- The service had started providing the regulated activity in February 2023, since that date there had been 3 different managers in post. The provider had failed to put in place effective systems to maintain oversight and information within the service. The lack of effective systems had resulted in the current manager having limited information and a lack of systems to ensure a safe and good quality service.
- The manager in post was unable at the time of the inspection to access and provide governance information. This included policies and the service's contingency plan.
- Records had not been suitably maintained. This is a regulatory requirement. For example, during the inspection a person raised a concern about an incident that had happened overnight. When the records were reviewed, we found staff on shift had failed to make a single written entry during that period. This meant it was difficult to fully establish what had occurred and what actions had been taken in response.
- Many medicine administration records (MAR) charts were handwritten by staff. The handwriting was not always legible, and some had been obscured by hole punches. This meant there was a risk of people receiving incorrect medicines due to unclear MAR charts.
- The local authority quality monitoring team had visited the service in March 2023 and identified improvements were needed. Despite this these improvements had not been made and the quality of the service had deteriorated. This meant the systems in place were not effective at driving improvements.

Effective systems were not in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- No systems and processes were in place to ensure people and staff were consulted on the running of the service. No staff meetings or resident meetings had been held. No feedback on the quality of the service had been sought.
- The management team were not able to provide evidence of people and their relatives involvement in the

support provided.
● People and relatives told us there was poor communication across a range of areas. This included management changes as well as people's individual care. One relative told us, "The communication was terrible."
● The lack of systems and communication has contributed to people receiving a poor-quality service which did not meet their needs and was not person-centred.

The provider had failed to implement systems or processes to seek feedback and evaluate the care provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visits the provider worked with local authority and health professionals to address the serious concerns identified and ensure people's safety. This included working with professionals to identify where people's needs could not be safely met within the service and supporting the identification of alternative services.

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 lack of systems and processes around incidents meant incidents were not formally recorded, reported, and reviewed. This meant we could not be certain requirements under duty of candour would be met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Actions to mitigate risks of harm to people were not effective. Not all risks to people had been assessed and considered. Effective actions had not been taken to prevent and control the risk of infection. Medicines were not safely managed, and people did not always receive medicines as prescribed.

The enforcement action we took:

We served a notice of decision imposing conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Effective systems were not in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We served a notice of decision imposing conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure staff were suitability skill and competent to deliver care and support to people living in the service.

The enforcement action we took:

We served a notice of decision imposing conditions on the provider's registration.