Mrs Jennifer Grego

Sunnyside

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sunnyside is a residential care home providing personal care and support for adults with learning disabilities, autism and mental healthcare needs. The service is registered to accommodate up to four people and there were four people living at the service at the time of the inspection.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. However, not all of the principles had been applied to the service provided, to ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service should also receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

Thematic Review
The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

As part of thematic review, we carried out a survey with the manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people. The service did not always support people effectively in line with positive behaviour support principles. Staff were not all suitably trained to support people using positive behaviour support. The service was not able to demonstrate that use of physical restraint was appropriate to manage peoples distressed behaviours.

People's experience of using this service and what we found
People were not always supported by enough suitably trained staff. This was confirmed by feedback from people's relatives.

We identified significant environmental risks and concerns impacting on the standards of safe care being provided. Leadership and governance arrangements within the service had further deteriorated since the last inspection.

We identified breaches of regulation and the provider, in the absence of a registered manager, was not meeting their legal regulatory responsibilities to ensure people received good standards of care.

People were not always supported to have maximum choice and control of their lives. Staff did not always

support them in the least restrictive way possible; policies and systems in the service were not followed to support good practice or reflecting the principles and values of Registering the Right Support.

Feedback from people's relatives raised concerns around levels of activities and social stimulation. The service had not put in place end of life care planning, and care records did not consistently contain protected characteristics in relation to personal choice and preferences.

The care environment was clean, and people had the option to personalise their bedrooms. The manager was working with staff to improve morale and staff cohesion, with changes to staffing rotas and supervision structures.

Rating at last inspection
The last rating for this service was Good overall with Requires Improvement in the well-led key question of the report, (published 17 January 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches of regulation in relation to safe care and treatment, safeguarding people from harm, consent to care and support, provision of person-centred care and having good governance systems and processes in place.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will arrange to meet with the provider. We will work alongside the provider and Local Authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

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

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 effective.

Details are in our effective findings below.

Inadequate

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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Sunnyside

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
There was one inspector.

Service and service type
Sunnyside is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was in the process of registering with the Care Quality Commission and had been in post since April 2019. For the purposes of the report, they will be referred to as the manager. The last registered manager had deregistered from the service in March 2019. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people and staff at the service to speak with us.

What we did before the inspection
Before the inspection: We reviewed information, we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection: We spoke with, and observed, care and support provided to all four people who used the service. We spoke with the manager, operations manager, two senior care staff and two support staff. We looked at two people's care and support records and three people's medicine records. We also reviewed staff files as well as records relating to the management of the service, recruitment, policies, training and systems for monitoring quality. We attended the morning staff shift handover meeting.

After the inspection: We spoke with two people's relatives by telephone after the inspection visit. We liaised with the local authority safeguarding and quality assurance teams. We requested provision of additional information from the service, and this was provided within agreed timescales.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated and is rated as Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were unable to tell us if they felt safe living at the service. However, one relative told us they were concerned about people's safety due to recent incidents of one person assaulting other people. They told us this was causing people anxiety and impacting on their wish to return to Sunnyside following home visits.
- We reviewed information on incidents, accidents and use of physical intervention such as restraint. We identified three safeguarding incidents that had been reported to the Local Authority safeguarding team but not to CQC in line with the service's regulatory responsibility.
- The manager told us there had been three incidents where physical restraint had been used in August 2019 and that staff were trained in the use of de-escalation techniques to support people in the management of behaviours which challenge and in use of restraint. From reviewing incident forms and corresponding physical intervention paperwork, there had been five episodes of restraint recorded in August 2019. From the training matrix provided by the manager, for three of the times restraint was used, the staff who completed the intervention were not listed as having current physical intervention training. The circumstances leading up to and including use of physical intervention by staff had not been reported to the Local Authority safeguarding team or to CQC.
- Staff did not demonstrate that they were following the service's policies and procedures in relation to keeping people and themselves safe. Only 47% of staff were listed as having current safeguarding training, with the remaining staff booked on training.

People were not consistently being kept safe and protected from harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a recorded log of accidents and incidents. However, the level of detail and recording of managerial oversight was poor. We were therefore not assured that the manager was implementing actions to reduce the risk of reoccurrence where applicable.
- Care records did not always contain detailed assessments and risk management plans formulated by the service. For one person who had been living at the service for approximately two months at the time of the inspection, their care record mainly contained care plans and risk assessments from their previous placement. Some of the documents staff had access to, from the previous placement had been written up to two years before, therefore it was unclear if their content remained relevant. At our request, the service put further risk assessments in place.
- Care records did not include consideration of environmental risks linked to people's individual risk histories. For example, consideration was not given to access to risk items such as large amounts of

personal care products, or items that could be used to cause harm such as computer cables, and sharp items such as razors. Access to such items was not reviewed following incidents. For example, we identified that a person had repeatedly attempted to tie ligatures around their neck to either fixed or unfixed points. [A ligature point is the term used to describe a place or anchor point to which persons, intent on self-harm, might tie something to for the purpose of strangling themselves], and no updates had been made to their corresponding paperwork or adjustments made to the environment.

●We identified other environmental risks such as uneven surfaces in the back garden, and loose bricks which could be used as a weapon or to cause damage to property.

●One person's care record detailed increased risks around developing sepsis [a potentially life-threatening response to infection], linked to behavioural risk presentations. The service did not have a sepsis policy in place to provide guidance for staff about this condition, what health indicators they needed to be monitoring, or what action they needed to take.

Risks to people and the care environment were not well managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our request, the service reviewed people's access to risk items and worked with people to make adjustments to their living environments. The service also provided assurances that an order had been placed for equipment to remove a ligature in the event this was required. The manager told us that after the inspection, warning signs had been put in place regarding uneven surfaces, and that a full check of the garden and surrounding outside area had been completed and risk items removed.

●Detailed Personal Emergency Evacuation Plans (PEEPS) and fire risk assessments were in place, recognising specific support needs for people with learning disabilities and autism. 42% of staff had current fire safety training, with remaining staff booked to attend training.

●Equipment for fire safety and water quality checks were regularly completed to ensure that they worked correctly.

Staffing and recruitment

●Relatives reported concerns about staffing levels, and staff turnover. One relative told us there were only one or two staff members that had been in post since October 2018 and told us they worried about the impact staff changes and inconsistency had on people. Another relative told us that newer staff were less familiar with people's needs.

●Staffing at night had been increased to two members of staff due to increased risk presentation within the service. (One awake and one asleep). However, we were told after the inspection visit that funding for the second night staff member had ceased.

●There had been a number of incidents in the weeks leading up to the inspection, which required a response from more than one member of staff at night. Lack of an additional staff member placed staff and people at increased risk of harm.

●The ratio of male and female staff on shift had not been fully considered. We identified some night shifts with only male staff on shift. Staff told us that this was not in line with one of the people's personal preferences if requiring assistance with personal care. With reduction in night staff this preference would not be met at all times.

●We identified risks for female staff lone working at the service, linked to people's historic risk profiles. This had not been identified by the service.

●The manager had introduced new lone working procedures so that staff phoned between services at agreed time intervals, and there were procedures in place in the event the phone was not answered. However, this did not mitigate risks linked to working alone, or the amount of time that could pass before

anyone was aware there was a problem.
●Staff did not have access to regular breaks during 12-hour shifts.

There were not always enough staff to be fully responsive to risks and meet people's needs, particularly at night. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The manager told us the staffing rota had recently been redesigned, with flexibility built into the staffing levels to allow for activities and attendance at appointments and to ensure staff had regular blocks of time off.
●Safe recruitment practices were in place to ensure staff were suitable to work with vulnerable people.

Preventing and controlling infection
●During the morning shift handover meeting, it was identified that a person had been unwell overnight and required staff support. Staff did not discuss any prevention measures to reduce the potential risk of spread of infection between people living at the service. This placed people at risk of cross infection.
●The service was clean throughout, with no malodours identified. Regular audits of the environment including of cleanliness, were in place including spot checks of people's rooms and communal areas. Where able, people were encouraged to keep their rooms clean with support from staff as required.
●Staff had access to personal protective equipment such as aprons and gloves.

Using medicines safely
●At the time of the inspection, 42% of staff had current medicines management training, with the remaining staff booked to attend training courses. This did not guarantee that staff on site all had up to date training in place when required to give people their medicines.
●There were systems in place for ordering and giving people their medicines as prescribed. Medicines were given by staff and recorded on Medicine Administration Records (MARs).
●There were regular checks of medicines and the MARs and there was a system in place to report incidents and investigate errors relating to medicines. People received regular reviews of their medicines by healthcare professionals.
● The provider had changed storage arrangements for medications as needed to manage risks. However, individual risk assessments had not been updated. The manager confirmed that people's risk assessments had been updated following the inspection visit.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated and is rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Where people experienced behaviours which challenge, the service had implemented Personal Behavioural Support (PBS) plans. When we reviewed the content of these plans, these did not accurately reflect the support, interventions and restrictive practices that people required and received. These plans were not being routinely reviewed and updated following incidents. The use of restrictive practices was not being monitored closely as part of people's wider person-centred support planning and in line with recognised best practice.
● The service did not always complete preadmission assessments for new people. They did not consider whether people would be compatible with those already living at the service, or whether the environment or staffing levels needed to be adapted to support the person to settle in.
●Care records contained variable levels of current detail and did not evidence whether they had been written collaboratively with the person and their relatives, if appropriate. They did not always reflect people's personal preferences.
● The manager was in the process of putting in place a document about people's needs and preferences that could travel with them if they needed additional care and treatment in an unfamiliar care environment.

● People who had transferred to the service from elsewhere, did not have updated, current care records. It was unclear if these records reflected people's current needs.

The care provided was not always tailored to people's individual needs and preferences. This was a breach of regulation 9 (Person-centred care) 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 Act 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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● 26% of staff had current MCA and DoLS training, with the remaining staff booked to attend courses. From reviewing people's care records and records of incidents staff were not routinely implementing this training into their practice.

●The service had submitted one DoLS application to the Local Authority and were awaiting authorisation. From our observations and discussions with staff and the manager, the main door to the service was being kept locked linked to the one DoLS application. Consideration had not been given to whether this was posing a blanket restriction on the other people living at the service, or whether there were less restrictive ways of managing this risk.

●The DoLS application form listed reasons for the application, such as the use of covert medicines [medicine mixed in food or drinks]. From speaking with the manager, this information was not accurate, as the person did not receive any of their medicines covertly.

●Where applicable, people's care records did not consistently contain capacity assessments.

●Staff consulted with healthcare professionals and family members when they considered making decisions on behalf of people in their best interests, but this information was not consistently recorded within people's care records.

Staff did not consistently work within the principles of the Mental Capacity Act (2005). This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

●The manager held a training matrix listing with current completion of courses and dates for when staff were booked onto training courses. At the time of the inspection, staff were booked onto multiple training courses, but completion rates were low.

●From reviewing the training matrix, we identified that staff did not have access to specialist mental health training which would aid their understanding and confidence to support people with complex support needs.

●Whilst the service had an induction programme for new staff, with staff shadowing shifts with experienced staff, we could not be confident that new staff were learning the right way to support people. This is because as identified, existing staff had not had sufficient training and development to meet the requirements of their role.

●Staff received regular supervision and annual performance-based appraisals, however, shortfalls in staff training, and performance had not been identified.

Staff did not have access to specialist training and were not up to date with the provider's mandatory training requirements. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

●Some people wished to explore healthy food options and make changes to their diet to aid weight loss. We checked with the manager who told us that they had not consulted with the GP or a dietician before assisting people to implement this decision. The manager told us they would speak with the GP and see if there would be the option for people to access local weight loss groups to increase social networks and external support.

●The service had a good working relationship with the local GP practice and learning disability healthcare

professionals.
●We observed people being encouraged to access the GP surgery when feeling unwell during the inspection visit.

Adapting service, design, decoration to meet people's needs
●Bathrooms, toilets, bedrooms and communal areas had varying levels of signage to assist people with familiarising themselves within the environment.
●People were able to personalise their bedrooms and the manager was working with people living at the service to make changes to communal areas to make them feel more homely.

Supporting people to eat and drink enough to maintain a balanced diet
●The service recognised the importance of people having a healthy and varied diet in relation to the maintenance of good health and wellbeing.
●There was a weekly meal plan linked to the household shop, and people were able to choose what they wanted to eat. Communal eating was valued as a social activity, however some people preferred to eat on their own and this was respected.
●People's weights were monitored, and the manager told us if the identified any concerns these would be referred to the GP.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated and is rated 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; equality and diversity

- Risks within the care environment, and individual risk management were not consistently mitigated. This was not conducive to a high standard of care.
- We observed most staff treating people with affection and taking the time to have meaningful conversations, the atmosphere was relaxed, and people seemed to be at ease. However, feedback received from people's relatives told us that due to the size of the service, if there was an incident everyone living at the home picked up on this and this in turn caused people to experience episodes of increased anxiety.
- When people approached staff or showed signs of distress, staff responded to their requests and provided reassurance, however, at times people remained in the communal lounge with the inspector who they were unfamiliar with, while staff completed other tasks. People approached the inspector for reassurance and support.
- Staff knocked before entering rooms and explain to people what they were going to do before and during the completion of tasks.
- Staff told us how important it was to treat people with kindness. One staff member said, "Our role is to nurture people, build up their confidence and promote their independence."

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

- From the care records reviewed, people and their relatives had not been asked for their views on the use of restrictive interventions or had the opportunity to discuss, contribute and learn about use of Personal Behavioural Support in line with recognised good practice.
- The service had a running programme of meetings for people living at the home. Agenda items were discussed, and people were given the opportunity to give feedback and suggestions for ways to improve the service. This gave people the opportunity to feed their ideas into the running of the service. Pictorial information was being developed to further assist people with their communication.
- The manager had held a recent barbecue as a way of getting to know people's relatives.

Respecting and promoting people's privacy, dignity and independence

- Bedrooms were personalised, with people having objects and items of personal importance on display. Privacy frosting had recently been installed on bedroom and lounge windows.
- The service had the potential to enable people to develop greater levels of independence and told us they were in the process of reviewing the design of people's care records to make information more accessible.
- Some people attended college and further education courses during term time.

●Care records contained guidance for staff on methods of communication and interaction for people with sensory impairments or experiencing changes in their behaviour or mental health presentation. However, some of the information lacked detail.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated and is rated Require Improvement. This meant people's needs were not always met.

End of life care and support

●There was no one receiving end of life care at the time of the inspection. The service had identified the need to make improvements around end of life care planning and provision. There was not end of life care training available as part of the service's mandatory training programme.

●Care records examined did not consistently contain details of protected characteristics such as cultural and spiritual beliefs and preferences.

●The manager told us they had completed additional training and planned to offer coaching and support to the team to support them with having conversations with people and their relatives.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●Care plans contained some information for staff to follow to support people with completion of tasks including personal care, eating and drinking, and other aspects of daily activity. Care records did not consistently contain a breakdown of how people wished for their needs to be met, for example, at different stages of the day.

●Some guidance was in place for staff, to assist people in expressing their wishes and daily needs. The manager told us they were in the process of developing use of pictorial information and daily planning boards to improve this process.

●Where needs were identified, the service implemented accessible communication standards for example providing information face to face rather than in a written format. However, care records contained limited information, and there needed to be greater consideration given to when people experienced episodes of being mentally unwell or episodes of increased agitation or distress, and the potential impact this had on their abilities to communicate.

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

●Staff supported people to choose and purchase gifts and cards to give to relatives to celebrate birthdays or visits home, to ensure they maintained regular contact with families and people important to them. One relative told us how pleased they had been to receive a gift.

●People's care records contained some details of people's hobbies, interests and personal goals. Where possible, staff supported people to access activities in the local community to reduce social isolation.

However, we received mixed feedback from relatives on whether they felt people had access to enough activities and stimulation during the week and at weekends. One relative told us they had escalated their concerns regarding the lack of sufficient activities to the provider.

●On the morning of the inspection visit, one person was completing a jigsaw puzzle and one person was listening to music. Three people then went out in the car to purchase some lunch.

Improving care quality in response to complaints or concerns

●Relatives consistently told us that if they had any concerns or needed to raise a complaint either with the manager or the provider, they would feel comfortable to do so.

●Where the service had received concerns or complaints, these had been investigated in line with the service's policies and procedures.

●The service kept a log of compliments and had received positive feedback. Examples included from healthcare professionals and from a relative following the recent barbecue.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated and is 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- We identified multiple incidents and safeguarding concerns which had either been shared with the Local Authority and not with CQC, or not shared with any external body. The manager was therefore not clear of their regulatory responsibility in relation to completing notifications to CQC and in monitoring performance and risk. This did not provide us with assurances that people were consistently being kept safe.
- Robust systems were not in place for monitoring the use of restrictive intervention, including physical restraint. Paperwork reviewed lacked detail, was inconsistently completed and did not demonstrate that the person's human rights and welfare had been upheld throughout the process. This was also not in line with the service's own policies and procedures.
- Overall staff training completion rates were low, with a lack of role specific training in place to ensure staff have the required knowledge and skills to meet people's needs and associated risks.
- The service did not complete its own dependency tool to review people's changing support needs against the number of staff required to meet those needs on each shift.
- There were quality audits and spot checks being completed, but shortfalls in the service and care environment found during the inspection had not been identified through these processes. We were therefore not assured that processes in place were robust, and that those staff completing the audits fully understood what they were checking for. This was of particular concern in relation to gaps in recording linked to management of risks for people and the care environment.
- Quality monitoring processes to identify and address shortfalls was an area of concern identified at the last inspection.
- The service has had inconsistent leadership which has impacted on continued service improvement. The service has not sustained a good rating since the last inspection, and multiple breaches of regulation have been identified at this inspection. In the absence of a registered manager, greater oversight of the service should have been in place by the provider as they have overall legal responsibility and accountability for how the service is run and for the quality and safety of the care provided.
- People's care records did not consistently demonstrate examples of collaborative working with healthcare professionals and the people receiving the service. Where people had Positive Behavioural Support (PBS)

plans in place, these were not reviewed and updated to reflect changes in approach and people's presentation, following incidents.
●Further work around the development of person-centred care provision was required. Care records lacked key details and were not being routinely reviewed and updated following incidents, to reflect changes in risk and presentation.
●Improvements had been made to the shift handover process and the allocation of tasks at the start of each shift to improve staff accountability. Staff were also responsible for completing daily directives about each person, however we identified shortfalls in paperwork completion that had not been identified and from sample reviewed, staff were not recording consistent levels of detail. This was of particular concern where people's risk presentation was changing.
●We identified that the service was not adhering to The Health and Safety at Work Act (1974), in relation to suitability of staff footwear. We observed staff to be wearing open toe, slip on shoes which would not offer suitable protection.
●The management team had introduced regular staff meetings and incorporated discussions around policies and procedures and areas of learning and development into these sessions. However, due to the level of concern identified at this inspection, we could not be assured these meeting were effective.

Due to poor governance systems and processes in place, people were not protected from risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The manager was working with the staff to address historic cultural issues within the staff team and to improve cohesion and morale. As a starting point, changes had been made to staffing rotas so staff worked in consistent teams, with supervision and support structures built in. This approach was still being embedded at the time of the inspection visit.
●Staff described the new manager as supportive and spoke positively about changes being implemented within the service, but recognised that changes would take time, and the management team needed to remain stable to oversee longer term change and improvement.
●Since the last inspection, a staff and visitor toilet had been installed overcoming the need for a person's ensuite to be used.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
●People and their relatives could provide feedback through the compliments and complaints process in place, with information accessible when visiting the service.
●Staff told us they felt listened to by the management team and encouraged to make suggestions about ways of changing the service.

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 care provider was not always providing person-centred care in-line with people's wishes and preferences or in line with best practice. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not always working within the principles of the Mental Capacity Act (2005). Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not always assessing risks to people and the environment, and putting measures in place to mitigate risks and keep people safe from harm. Regulation 12 (1) (2) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment The care provider was not consistently protecting people from risk of harm or abuse. They were not following their own safeguarding policies and procedures and had not ensured incidents and safeguarding concerns had been notified to CQC and external stakeholders. Regulation 13 (1) (2) (3) (4) (b) (d) (7) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance processes and procedures in place. Audits and quality checks were not identifying risks and concerns found during the inspection including areas of unsafe practice. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider was not ensuring there were consistently sufficient staff, with the necessary skills and training to meet people's care and support needs. Regulation 18 (1) (2) (a)