Ambient Support Limited

80 Meridian Walk

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

About the service
80 Meridian Walk is a residential care home providing personal care to six people at the time of the inspection. The service can support up to six people.

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

Right Support
The service did not support people to have the maximum choice, control or to be as independent as they could be. While people's bedrooms were highly personalised, the communal areas of the home were in a poor state of repair and were not homely. For long periods during the inspection people were left with minimal stimulation and engagement while music played and the television was on with a low volume. There was limited evidence that people were supported to explore their interests. People had been assessed as lacking capacity to consent to their care and treatment. Where specific decisions needed to be made, appropriate best interest decision making processes had been followed. People were supported by staff to take their medicines, but records contained conflicting information about what medicines people were prescribed.

Right Care
Staff knew about people's cultural backgrounds, but there was a reliance on people's families to meet cultural needs. Staff knew people and their needs but did not demonstrate compassion or respect in their interactions with people. Information about people's communication needs and styles was limited and some information showed misunderstandings about different tools of communication. People's care was not planned in line with best practice guidance; people were not supported to identify goals or ambitions. People were not receiving care as planned and were rarely supported with activities and were not active members of their community.

Right culture
Staff were not ambitious for the people they supported and did not show they understood how to engage people with all aspects of their own lives. The service had recently recruited additional staff but the use of agency staff to fill rotas remained high. The agency staff were well known to people but the way staff were deployed showed there was a task focussed approach to support. The provider had allowed a culture of low ambition and aspiration to flourish in this home.

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 good (published 26 February 2018)

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right Support Right Care Right Culture.

This inspection was prompted by a review of the information we held about this service.

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.

Enforcement
We have identified breaches in relation to Person Centred Care, Dignity and Respect, Safe Care and Treatment and Good Governance.

We served the provider and registered manager with Warning Notices which required them to meet the regulations by a specified date.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always 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.

80 Meridian Walk

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by one inspector.

Service and service type
80 Meridian Walk is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement depending on their registration with us. 80 Meridian Walk is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during the inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our insepction there was a registered manager in post.

Notice of inspection
We gave a short period notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection

What we did before inspection
We reviewed the information we already held about the service. This included information collected through our monitoring activities and feedback from relatives. We sought feedback from the local authority and safeguarding teams. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with two people who used the service. We spoke with one family member and received additional feedback from three other relatives. We made extensive observations of the care and support people were receiving. People who used the service who were unable to talk to us used different ways of communicating. We observed their body language and how they reacted to staff and the environment around them.

We spoke with five members of staff including the registered manager, the regional manager and three support workers.

We reviewed a range of records. This included three people's care records and their medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We sought clarification from the Provider about some issues and received and reviewed additional information including audits, records of care and other records relevant to the management of the service. The provider sent us further information and updated records.

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 changed to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks were not always appropriately identified and mitigated. People's care plans contained risk assessments in relation to some aspects of care but other risks had not been properly identified.

●One person had bedrails in place due to the risk of them rolling out of bed. However, there was no risk assessment in place to ensure bedrails were used safely. The registered manager initially told us there was a risk assessment but they were unable to find it. They said, "We haven't got one [a bedrails risk assessment]. We'll have to do that."

● There was no risk assessment in place regarding skin integrity and risk of pressure damage for this person. The registered manager told us this wasn't necessary but their mobility risk assessment had identified risks associated with their seating and developing pressure wounds. The registered manager told us this related to an old chair and that risk assessment was out of date.

● Risks associated with malnutrition had not been assessed. One person had last been weighed in January 2020 when a low body weight was recorded. Their care plan said their weight should be monitored at the day centre. However, they had not attended the day centre since the start of the pandemic in March 2020. The risks associated with their weight and nutritional intake had not been assessed.

● Other risk assessments had not been updated to reflect changes in people's needs. For example, one person was being treated for a pressure wound but their personal hygiene risk assessments had not been updated to reflect changes required during treatment. The fire risk assessment and evacuation plans had not been updated to reflect changes in people's mobility.

● Risks associated with fire and evacuation had not been properly assessed or mitigated. People's evacuation plans did not reflect their mobility needs. Risk assessments relating to staff capacity to physically support an evacuation were not fit for purpose.

The failure to ensure risks were properly identified and mitigated is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the site visit the provider started to update risk assessments and take action to improve the fire safety in the home.

Using medicines safely

● Medicines were not always managed safely. While staff recorded the medicines they administered clearly, information about people's medicines was unclear and care files contained conflicting information.

● Information about people's medicines was recorded in different places within their care files. There were

discrepancies in the information about what medicines people were prescribed which meant it was not clear what the most up to date record of people's medicines was.
● Guidance for medicines prescribed on an 'as needed' basis was not always clear. Several people living in the home suffered from regular and severe constipation and were prescribed a variety of medicines for this condition. The guidance was not clear about how long between bowel movements meant intervention was required and did not specify if one medicine should be used before another. One person had recently been hospitalised due to constipation but their records remained unclear.

The issues with medicines records meant medicines were not always managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recorded the medicines they administered clearly and this included stock checks.
● Staff received training in administering medicines and had their competency assessed.
● When medicines errors occurred appropriate action was taken to ensure people's wellbeing and staff practice was updated.

Preventing and controlling infection
● Infection prevention and control measures were not operating effectively to keep people safe from the risks associated with infection.
● Throughout the inspection staff were not wearing PPE in line with government guidance. The registered manager said they had advised staff they did not need to adhere to the guidance during the recent heatwave. They confirmed there was no risk assessment of this decision. However, the heatwave had passed and staff, including the registered manager, were not wearing PPE appropriately. Staff were either not wearing face coverings or they were not covering their noses and mouths.
● The kitchen and bathrooms were in a poor state of repair. Some surfaces and skirting boards had fatigued so the surface was compromised. They could no longer be cleaned effectively. The registered manager told us they had not thought to report the conditions in the bathrooms as they believed they were clean because they used disinfectant.

The failure to adhere to good IPC practice was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● There were systems in place to identify and respond to allegations of abuse.
● Staff had a good understanding of the different types of abuse people might be vulnerable to and knew how to report and escalate these concerns.
● Staff meeting records showed safeguarding was regularly discussed to ensure staff were up to date in their practice.
● Relatives told us they were confident their loved ones were safe from the risk of abuse.

Staffing and recruitment
● There were enough staff to meet people's needs. Staff had been recruited in a way that ensured their suitability to work in care.
● Family members confirmed they were involved in recruiting staff to work in the home.
● Although there were enough staff, they were not always deployed effectively to meet people's needs. We saw there were periods during the day when people were left unstimulated and unengaged while all the staff on duty completed domestic tasks such as tidying the kitchen or preparing a meal.

● Over the course of the pandemic there had been a high reliance on agency staff to maintain safe staffing levels. We saw the provider was taking steps to recruit permanent staff and was making progress in increasing the number of permanent staff.

● Relatives told us they worried that the high turnover of staff had an impact on their loved ones' experience of care. One relative said, "One of the things that concerns me is the very high turnover of staff. We saw lots of new faces. We hardly know any of the staff there now and I worry about that, do they really know [relative's] communication and what they like?"

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were described within their care plans. However, the plans on how to meet these needs did not reflect people's choices or current guidance on supporting people with learning disabilities.
- People's views about their care, their choices and preferences had not been explored with them.
- People's care plans did not include any goals or ambitions for their futures. There was nothing within the care files to show people had been supported to consider how they could develop links with their community and culture. The home relied on people's families to provide culturally specific food, but there were no plans in place to support people with their cultural identities.
- Care plans did not show that staff had considered people's diverse needs; there was no exploration of people's sexuality or sexual orientation. Nor was there any consideration of the impact of people's disabilities other than in relation to care tasks.

The failure to consider people's choices and preferences was a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider used an approach called "Active Support" where staff took steps to involve people more in all aspects of their care. Some staff had received training in Active Support in May 2022 and the provider was supporting staff to develop their skills in this area.

Supporting people to eat and drink enough to maintain a balanced diet
- People were supported to have their nutritional needs met, however, the mealtime experience was not person centred or appetising.
- People had swallowing difficulties which meant the consistency of their food had to be modified. Rather than keeping different elements of the meal separate staff were combining the whole meal which meant people were being asked to eat a very unappealing looking brown puree.
- Staff did not talk to people or engage with them while supporting them to eat. We saw a staff member only gave one person one attempt at feeding themselves before taking the spoon and moving a loaded spoon towards the person's face. Later, this staff member supported the person to have a yoghurt, as they had not wanted their main meal. They did not say anything to the person until they had a loaded spoon in front of their face when they then said, "[Name], you like it."
- People's care files showed several people preferred to eat food that reflected their cultural background.

The service relied on people's families to supply this food. One relative said that while they did not mind doing this, they worried that if they didn't their loved one wouldn't get the food they preferred.
● We told the provider about what we had seen during mealtimes. They told us they had purchased moulds and additional equipment to improve the presentation of people's food. We will follow up on the impact of these changes when we next visit the home.

Staff support: induction, training, skills and experience
● Staff received the support and training they needed to perform their roles.
● Staff spoke positively about the level of support and training they received when they joined the organisation. We spoke to staff who had not worked in care settings before and they told us the training supported them to understand their roles.
● Staff received training in areas that reflected the needs of the people they supported, including supporting autistic people and people with learning disabilities.
● Staff received a comprehensive induction which supported them to develop their skills as they progressed.
● Longer term staff did not always receive supervisions and appraisals in line with the provider's policy. The provider had a plan in place to address this.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access healthcare services when they needed them. However, as records were not always up to date there was a risk that people's healthcare needs might not always be met.
● For example, one person's care records showed in one place that they suffered from gastro-intestinal symptoms and were prescribed medicine for this. However, their health information made no reference to this and the medicine was not included on their medicines administration records.
● One person's health file said their behaviour could be effected by their menstrual cycle and this should be monitored to rule this out. Records had either not been completed or showed a pattern of menstruation that would require investigation by a healthcare professional.
● Health Action Plans are best practice in supporting people with learning disabilities with their health. They ensure all the important information about people's health needs is in one place, and available for all relevant healthcare professionals. The health action plans we viewed were poorly completed and did not provide clear information about people's health and the support they needed to stay healthy.
● Relatives gave us mixed feedback about the support their loved ones received with their health. One relative was very positive and said they were always kept up to date, but another was concerned staff did not always identify health issues.
● Staff told us, and care plans stated people attended other services. However, there was no record of any communication between services.
● One person was under the care of the district nurses but this was not captured in their care plan and there were no handovers of information recorded.

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 when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People were being supported in line with the MCA. Their support amounted to a deprivation of liberty and this had been appropriately applied for.
- None of the DoLS we reviewed contained conditions.
- The provider had assessed people's capacity to make decisions, and ensured best interests decision making processes were followed. However, people's ability to influence decision or express their choices was not well explored or documented.

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

- Some parts of the home were in a poor state of repair. People's bedrooms had been personalised to reflect their individual tastes.
- As identified in the safe domain, the kitchen and bathrooms were in a poor state of repair. The provider had recently ordered new carpets to replace the stained carpets from the communal areas.
- People had photographs of their families in their bedrooms, and each bedroom was distinct and reflected the different people who lived in the home. We saw families were involved in choosing replacement furniture when required.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now change to inadequate.

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
- Staff did not treat people well and the way they supported people showed they did not respect them.
- One person, who was unable to mobilise independently and had sensory impairments, was repeatedly moved out of the way of other people who lived in the home. Staff did not always alert the person before they were moved. Other people were also moved without being informed first.
- Staff were seen putting clothes protectors on people without alerting them or describing what they were doing.
- Staff repeatedly spoke about people and their presentation loudly to each other. They did this across the rooms while the person they were talking about, and their housemates, were in the room.

Supporting people to express their views and be involved in making decisions about their care
- People were not supported to express their views, or be involved in making decisions about their care.
- People were not involved in writing or reviewing their care plans. There was no information about how to involve people in a meaningful way to make choices in their day to day life.
- During a karaoke activity one person twice expressed they wished a staff member would stop singing. They reached across and clearly said, "Stop." Staff did not stop, they laughed and joked with each other how funny it was that the person had not liked the staff member's singing.
- Throughout our site visit we did not see people being offered choices. People were not asked what they wanted for lunch. People were asked if they wanted to have a drink but were not offered a choice of drink.
- There were no house meetings, or attempts to engage people with information about how they lived their lives.

Respecting and promoting people's privacy, dignity and independence
- People's dignity and independence were not promoted.
- Staff performed care tasks, such as wiping people's hands and faces, using rough kitchen towel and without talking to people to explain what they were doing.
- There was no information within people's care files about any independence goals people may have. People were not being encouraged to be ambitious for their lives.
- A relative told us they often found their loved one appeared unkempt when they visited.

The issues described across the caring domain are a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 now changed to requires improvement.

This meant people's needs were not always met.

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

- Care was not planned in a personalised way to meet people's needs.
- A relative told us, "They [staff] do the basics. Get them up, dressed and meals but I question his quality of life. I don't see any evidence that they do things, even just going for a walk in the park doesn't seem to happen."
- People's preferences were not documented so it was not clear they were met.
- Records of care were poorly maintained and did not demonstrate people received care in a way that met their needs and preferences. One person had no support recorded on 23 days out of 60. A second person had no support recorded on 33 days out of 91 and a third person had no support recorded on 11 days out of 30.

The failure to maintain appropriate records of care is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to maintain relationships with their family members. However, activities were extremely limited and people were not supported to live fulfilling lives.
- Family members had provided brief summaries of people's life stories and cultural backgrounds. Despite some people having lived at the home for many years no additions to their life stories had been made since they moved in.
- People had clear cultural identities but the only support provided to engage with these were to support them to eat culturally specific meals prepared by their families. People were not supported to attend community spaces associated with their cultures.
- People's activities were extremely limited and they were rarely supported to leave the house. One person's records of care showed they had not left the house since 10 June 2022 when the site visit took place on 22 July. This person only left the house once in the whole month of May.
- Another person only left the house to attend a day centre. Their care plan said they went four times a week. However, their records of care showed they had only attended 14 times in three months. They had not left the house with staff support in that time.
- Relatives told us they wished their relatives were supported to do more. One relative said, "[My relative] loves being out in the wheelchair and being pushed – just a simple thing they would enjoy but they aren't

doing things like that."
● One person's care plan stated they liked to go for drives in the service's van. A staff member told us the service had not had a vehicle for over two and a half years.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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.

● The provider ensured information about the service was available in alternative formats such as easyread. However, information about people's individual communication needs was limited.
● Each care plan contained a section on communication. However, the information was limited, and in some cases demonstrated a failure to understand communication approaches with people with learning disabilities.
● For example, one care plan referred to Objects of Reference (OOR). OOR are objects that can be used to support people to associate an object with an event, for example, car keys indicating a journey, or a particular bag meaning the day centre. This care plan described objects the person liked to hold as a comfort as being OOR. They were not OORs.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place and complaints were investigated in line with this.
● Relatives told us they knew how to complain, but that they did not feel there were opportunities for them to talk to the home about issues outside of formal complaints.

End of life care and support
● No one living at the home was receiving end of life care and support. It was not clear whether people and their families had been encouraged to consider planning for the future.
● It was clearly recorded that people should be resuscitated in the event of a cardiac arrest. This had been made explicit in people's care plans in response to national concerns about people with learning disabilities being disadvantaged regarding treatment and decisions about resuscitation during the pandemic.

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 good. At this inspection this key question has now changed to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Managers, including the registered manager, had not taken action to effectively monitor quality, risks and regulatory requirements.
- There were systems in place for the registered manager to undertake regular audits of different elements of the service. These had failed to identify or address the issues found during the inspection. In some areas the audits had recorded incorrect information. For example, they recorded the home was "very clean" and in a good state of repair. This was not the case.
- The systems in place had not identified that care records were not being completed.
- The provider had a system of oversight audits completed by an area manager. The audit completed in April 2021 had identified many of the issues we found with care plans, risk assessments, health information and person centred care. These issues had not been addressed despite being well known by the provider.
- A further oversight audit had taken place in January 2022. This had shown many of the issues first identified in April 2021 persisted. Despite this, no effective action had been taken to improve the quality and safety of the service by the time of our site visit in July 2022.
- While there were some action plans in place these were not comprehensive and had not been effective in driving improvements or learning from the audits completed.

The above issues are a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the site visit the issues identified at the inspection were escalated to the regional manager. They took immediate action to address the most serious of our concerns and implemented an additional programme of independent audits and quality assurance. They implemented the provider's internal service improvement process.

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

- Despite the provider having a strong, person centred values base this was not embedded at the home and people were not being supported to achieve good outcomes.
- The staff we spoke with talked about the people they supported with compassion and kindness. However,

our observations showed this was not embedded in practice.
● There were no clear outcomes or goals for people to achieve and no records to show any outcomes had previously been achieved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● While there were regular staff meetings, there were no efforts made to engage people, their relatives or the local community.
● Relatives told us they were occasionally invited to parties or barbeques, but they were not invited to give feedback about the overall quality of the service or to attend meetings about the home.
● There were no meetings for people who lived in the home, or efforts to engage them in a meaningful way about decisions within the home. There was no consideration of how their disabilities affected their communication and the need to find creative ways of engaging with people.
● Notwithstanding the recent restrictions related to the COVID-19 pandemic, staff had made no effort to engage the local community; people were not attending places of worship or cultural centres despite their religious beliefs and cultural identities being well known.
● Staff meeting records showed these were largely extended handover meetings. While some key management messages were cascaded, most of the records related to the people they supported and their day to day care needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibilities under the duty of candour.
● We escalated our inspection findings to the provider and they responded openly and honestly with us, taking immediate action to address some of the most serious of our concerns.

Working in partnership with others
● It was not clear that the service was working in partnership with others.
● Although people attended other services, there were no records to show staff shared information and worked to a common purpose.

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 People's care was not planned or delivered in a person centred way. Regulation 9

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. Regulation 10

The enforcement action we took:

We issued a warning notice against the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been properly identified, assessed or mitigated. Regulation 12.

The enforcement action we took:

We issued a warning notice against the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to monitor and improve the quality and safety of the service. Records had not been properly maintained. Regulation 17.

The enforcement action we took:

We issued a warning notice against the provider and the manager.