Achieve Together Limited

St Albans House

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?	**Requires Improvement**
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
St Albans House is a residential care home providing personal care to 5 people at the time of the inspection. The service can support up to 5 people.

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

Right Support: People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: Care is not sufficiently person-centred and does not adequately promote people's dignity, privacy and human rights

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff does not adequately ensure people using services lead confident, inclusive and empowered lives.

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 01 December 2020 and this is the first inspection. The last rating for the service under the previous provider was good, published on 27 March 2019.

Why we inspected
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.

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

Enforcement
We have identified breaches in relation to the systems and processes to protect people from abuse and

improper treatment; the systems to ensure care and treatment was provided in a safe way for people and the systems to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service.

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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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?

Requires Improvement

The service was not always 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.

St Albans 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
1 inspector carried out this inspection.

Service and service type
St Albans 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. St Albans 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 a registered manager in post. The registered manager of St Albans House was also a regional manager with oversight of a number of services. The service manager at St Albans House had recently left to focus on managing another Achieve Together service. A registered manager from a nearby Achieve Together location had been acting as manager of St Albans House as well as the service they were registered manager at, in an interim position, while recruitment for a new registered manager was

underway. The interim manager shared their time between St Albans House and the other nearby location.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 28 March 2023 and ended on 20 April 2023. We visited the location's service on 28 March 2023 and 5 April 2023.

What we did before the inspection
We reviewed information we had received about the service. We received a Provider Information Return (PIR) from the service. 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 reviewed information compiled after a direct monitoring call with the service. We reviewed information received into our system for ongoing monitoring of the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 2 relatives, we spent time observing people and the care they received. We sent emails requesting information to additional relatives but did not receive a response.

We spoke with 6 members of staff including the registered manager. We sent 13 emails to staff members requesting feedback about the service and received 4 responses.

We reviewed a range of records. This included 2 people's care records and medication records. We looked at 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 looked at training data and quality assurance records.

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.

Systems and processes to safeguard people from the risk of abuse

- The provider failed to ensure people were kept safe from avoidable harm. The staff team knew people well however, systems and processes did not adequately protect people from abuse.
- People were subject to restraint without robust processes and procedures to support this practice. This included physical, environmental, and chemical restraint. Behaviour of concern reports reviewed for one person referenced the use of 'clinical holding' and 'support holding'. It was unclear what these terms meant as within the reports they referenced holding a person to calm them down. This meant people were at an increased risk of being restrained inappropriately and at risk of harm. Staff knowledge of 'clinical or support holds' was not in line with the providers own policy. In addition, we did not see evidence of agreement from a multi-agency team that this support was appropriate for people
- Documents reviewed demonstrated 'as required' (PRN) medication was used 'for behaviour management' for one person, on at least 16 occasions across 10 months and not recorded as a restrictive practice. Additionally, there was no reference to the management of administering chemical restraint medicine in the person's care and support plans or in a 'challenging behaviour' risk assessment. This placed the person at an increased risk of harm.
- People were subject to environmental restraint and the deprivation of their liberty without robust processes and procedures to support this practice. For example, we reviewed records which showed people were locked in their rooms or the communal kitchen area when a person in the service was showing signs of anxiety or distress. This placed people at an increased risk of harm.
- Staff had training on how to recognise and report abuse however, this learning was not consistently applied. For example, at least 49 incidents were reported onto the organisations electronic system regarding one person across a 10 month period, including accidents and behaviour of concern reports and these were not recognised by the provider, manager, or staff team as incidents of possible or actual harm to the person or other people who lived at the home. This placed the people who live at the service at risk of harm.
- Staff spoken with stated they had received training in safeguarding adults. Training records reviewed showed the staff team had completed safeguarding training. However, incidents where people were placed at risk of harm were not routinely identified as safeguarding concerns or reported as such.

Systems and processes had not been established to protect service users from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks were not well managed or sufficiently mitigated to keep people safe. Action was not taken to mitigate the risk of possible harm to people who live at the service. For example, 39 behaviour of concern

reports were reviewed regarding one person across a 10 month period. The behaviour and incidents recorded showed similar examples of behaviour across this time which were impactful on all the people at the home. Action was not taken to address these incidents and they continued to occur.
● Incident reports were not adequately reviewed to identify risks to people and measures were not adequately taken to adopt suitable control measures to make the risk for people as low as possible.
● Risks were not adequately identified in terms of their severity. For example, one person spat, shouted, swore and used threatening words about the staff team and the other people at the service and used self-injurious behaviour and this was deemed to be a minor risk.
● The service did not sufficiently identify the risks to safety of people who live at the service. For example, one person who had a tendency to have seizures, had 4 recorded unwitnessed falls in 6 months. One of these resulted in serious injury and there were two further recorded falls after this incident. Documentation reviewed did not detail how the ongoing possibility of unwitnessed falls would be managed or how the risk of harm to this person would be lessened.
● The service did not keep people safe through formal sharing of information about risks. For example, we saw individual risk assessments were not completed to reflect all risks for people or consistently updated. One person demonstrated behaviour that placed them and others at risk of sexual safety and this was not reflected in their risk management plan. One person had a 'challenging behaviour' risk assessment, which did not reflect the action the staff team were taking to manage this and was therefore not current. A second person at risk of unwitnessed falls had a risk assessment which stated they were injured, when this was no longer the case. The actions to mitigate risk of falling included to wear sturdy shoes at all times, and to cover hard edges in foam. These are not sufficient actions as the repeated falls demonstrate.

Systems had not been established to ensure care and treatment was provided in a safe way for service users. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim manager had taken action to address some of the risks identified including involving the provider's positive behaviour support team; increasing staffing levels and having locks fitted to the bedroom doors of all people who live at the service.
● People, including those unable to make decisions for themselves, had some choice and control over their lives. For example, some people were supported to go out to lunch locally, to shop for specific items and to go out with family. One person who used to enjoy going to the pub and had not been for a substantial period of time, had recently been able to start doing this again, with support.
● There were appropriate health and safety checks carried out at the service. For example, a fire risk assessment had been carried out by an external company, the gas safety certificate and other safety certificates were reviewed. There were recommendations made on the fire risk assessment and the interim manager told us these had been or were being completed.

Staffing and recruitment
● The service had enough staff to cover the shifts identified on the rota, however, at the time of the inspection there was one staff vacancy. Staff spoken with during the inspection told us there were not enough staff to manage situations where there were escalations in people's behaviour and doors had to be locked to keep people safe. However, after the inspection the same staff members stated that there were now enough staff as the interim manager had updated the rotas to include an extra staff member as a mid-shift. We reviewed four weeks of rota and saw that originally there were three staff on duty each day, but that in recent weeks an additional staff member had been introduced to ensure 4 members of staff across the day.
● The process for staff recruitment was satisfactory.

Using medicines safely

● The service used 'as required' (PRN) medicine to manage the behaviour of people at the service. Although these medicines were prescribed, documents reviewed did not detail the behaviour triggers or escalation whereby these could be administered, by who, how or what monitoring processes were in place. It was not clear who had oversight of the administration of these medicines and behaviour support plans reviewed did not reference their use.

● People were supported by staff who completed training in medication. There were systems and processes to administer, record and store medicines, however, this was not sufficient regarding PRN medication for the management of behaviour. Records reviewed showed us the established staff team had completed training in medication. Some of the staff team had completed training in epilepsy awareness and the administration of emergency medication. Medicines competencies were undertaken by the staff team and documents reviewed showed that 7 staff had completed these at the time of the inspection.

Preventing and controlling infection

● The service used infection, prevention, and control measures, and staff supported people to follow them. We observed the premises to be clean.

● Infection prevention and control (IPC) audits were requested and 1 was completed in a driving up quality (DUQ) audit dated December 2022. A second driving up quality audit from March 2023 did not have a completed IPC audit. This was sent after the DUQ, but it was unclear who had completed it or when it was done as there was no name or date.

● Staff had completed food hygiene training.

Visiting in care homes

● The service supported visits in line with current guidance.

Learning lessons when things go wrong

● The service had a system to record and report incidents affecting people's safety. Staff recognised incidents and reported them using the organisation's electronic system. The reports were not always completed fully and did not clearly identify the use of restraint. This was not identified by the service manager or their line managers.

● The staff team did record and report incidents, however these were not investigated and therefore the risks and behaviours and accidents continued to occur across at least a 10 month period. One staff member told us that incidents were repeatedly reported, but that nothing ever happened to address these.

● The interim manager had added a lessons learnt and action log section to the staff meeting minutes. An example of lessons learned, was a risk assessment devised to manage one person going into another person's room without their permission.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We found the service was not operating within the principles of the MCA or according to the organisation policy regarding DOLs. We found people were being deprived of their liberty and that physical, chemical, and environmental restrictive practices were in place, without these being authorised.
- DOLs had been applied and proof of the emails being received by Essex County Council was provided. However, the DOLs applications received were for only 4 of the 5 people that live at the service. Additionally, restrictive practice and deprivation of liberty were in place for people prior to the DOLs being applied for. It has not been possible to determine what deprivations have been applied for on behalf of individual people at the service.

Systems and processes had not been established to protect service users from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People did not always have had care and support plans that were personalised, and which reflected their needs and aspirations, included physical and mental health needs.

● The interim manager told us the care and support plans at the service were in the process of being updated. We reviewed the care and support plans for two people and saw these followed the Achieve Together organisational format, however they were not fully completed and information was not detailed. For example, in one support plan there was no information recorded regarding the person's personal identity; relationships and sexuality; mental well-being; physical well-being; being part of the community; intensive interaction.
● Guidance for the staff team on how to support people with their behaviours, choices and aspects of daily living was not always clear. For example, in the managing emotions section of the support plan there is reference to giving as required medication (PRN), which states, "There is PRN in place for (person) and the key is to get the PRN in at the right time, not leaving it to get to a major escalation before it is tried." There is no further information regarding this and the document does not suggest cross reference to any other documents that might contain more detail.
● A behaviour support plan for one person completed 22 December 2021 had not been updated to reflect the incidents recorded in their behaviour of concern reports and escalating behaviours across the past 10 months.
● Staff ensured people had up-to-date daily care and support notes completed in the form of a daily diary, however, these were not detailed. This meant that there was not a clear record of the care people were receiving.

Staff support: induction, training, skills and experience
● People were supported by staff who had received or had access to relevant training. This included how to work with people with a learning disability and/or autistic people such as mental health awareness, communication tools and positive behaviour support. One relative told us "The staff are really lovely," and another stated "All the staff are wonderful."
● There was a structured programme to update all training, and the staff team had access to and had completed or were completing a comprehensive training programme. Training requiring completion and updates were highlighted by the interim manager at a staff meeting in March 2023.
● The interim manager had begun to implement a process for staff to receive support in the form of supervision and appraisal. Documents reviewed showed these highlighted areas of strength and areas for development.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to eat and drink enough to maintain a balanced diet. The staff team had completed food safety training.
● People were involved in choosing their food and their choices were recorded at house meetings.
● Mealtimes were flexible to meet people's needs. We observed people eating the lunch they wanted when they wanted to.

Adapting service, design, decoration to meet people's needs
● People's care and support was provided in a clean environment which met people's daily living needs. We observed a lounge to the front of the house, which was designated for one person to use and a separate lounge at the rear with an adjacent dining area and kitchen which people were using. One person sat in the rear lounge watching TV. One person was in their downstairs bedroom. One person gave us a tour of the premises and showed us their bedroom.
● People personalised their rooms in the way they chose, reflecting their likes.

Supporting people to live healthier lives, access healthcare services and support
● People had health actions plans which reflected their health care needs. However, one person was seen to

have a diagnosis of asthma and of epilepsy and these were not referred to in risk assessments or support plans.

● We saw that people were supported to attend health reviews with external health care providers related to their specific needs.

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.

This is the first inspection for this newly registered service. This key question has been 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; respecting equality and diversity

- Staff were observed interacting with people who lived at the service and were seen to be patient and engaged. However, incidents that placed people at risk of possible or actual harm were not sufficiently identified by the staff team as being safeguarding concerns that required reporting to external stakeholders and this placed people at ongoing risk.
- Staff members spoken with were able to tell us about the people who lived at the service and had knowledge of the ways in which they communicated, and about their likes and dislikes.
- Staff members showed warmth and respect when interacting with people. We observed people being attended to by staff in a manner that demonstrated they knew the person well.

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

- People were given time to listen, process information and respond to staff. We observed conversations between staff members and people that were patient and considered.
- Where possible, people were enabled to make choices for themselves, and staff ensured they had the information they needed. For example, we observed one person make a lunch that they did not like. They were given a choice of other food they could have and supported to make something else to eat.
- People took part in making decisions and planning some of their care. Documents reviewed showed the service held meetings for the people who lived there, where they reflected on activities they had enjoyed and suggested ideas for food and future activities.

Respecting and promoting people's privacy, dignity and independence

- Staff knew when people needed their space and privacy and respected this. However, this had been impacted by behaviour which meant people's bedrooms were entered by other people at the service without their permission.

Requires Improvement

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 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

- People did not always have choice and control as they were deprived of their liberty by being locked in their room or the kitchen area to keep them safe when people exhibited behaviours that could place them at risk of harm.
- Three staff spoken with told us they had concerns about the safety of the people living at the service. One staff member told us, "There is a (risk) which has been reported countless times and nothing has happened. (People) shouldn't have to live in fear in a place we are meant to keep them safe"; another told us they sometimes had concerns about the safety of the people living at the service, "When one of the people we support starts to try (to) hit and kick other people that live in the house".
- Care and support plans were reviewed during the inspection and these were not consistently completed.
- Staff members provided people with personalised support in line with the information available in their support plans. One member of staff told us, "I spend (as) much time as I can with the person. Then I get to know them and can ask them (what their needs are). And as a support worker you learn to 'read' them and to listen to them and you learn over time."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The staff team had good awareness and understanding of individual communication needs. They knew how to facilitate communication and when people were trying to tell them something.

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 participate in social and leisure interests where possible. For example, people were supported to go out to town to buy something of their choice and to have lunch; to go out with family members where appropriate; family were welcome to visit people at the service and people were supported to visit family where appropriate.
- Staff provided person-centred support and everyday living skills to people. Staff members told us that they understood personal care to be "Respect, compassion, dignity for just (the) person I support," and "Ensuring the people who use our services are at the centre of everything we do."

● People who were living away from their local area were able to stay in regular contact with friends and family via telephone and video calls.

Improving care quality in response to complaints or concerns

● People, and those important to them, could raise concerns and complaints easily. However, at the time of the inspection there had been no complaints received at the service.

● There was a clear complaints structure in place.

End of life care and support

● Staff members were trained in the support and management of end of life care.

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

- Although there were governance systems established by the provider, they had failed to ensure they were implemented effectively in the service to keep people safe, protect people's rights or provide adequate care.
- The governance systems did not ensure risks associated with people's care needs were identified, reviewed, and mitigated in a timely manner. For example, between May 2022 and April 2023 the staff team completed at least 49 behaviour of Concern (BOC) reports for one of the people that live there, which detailed risk to themself, other people, and staff. Although these risks to the health, safety and welfare of people were reported, they were not adequately escalated through the organisation for them to be identified as risk and therefore measures were not put in place to reduce or remove the risk of harm.
- The management team, prior to the interim manager taking up post, did not have sufficient skill to perform their role. There was lack of oversight, which meant risk of harm to people was able to continue for at least 10 months. For example, where risk assessments needed updating or additional information was required this was delayed, leaving services users at potential risk of harm both regarding ongoing BOC reports that were not investigated or actioned and ongoing unwitnessed falls which continued without effective mitigation.
- During our inspection we requested an up to date report showing how analysis was being carried out to determine triggers for a person's behaviour. The report was reviewed and had only been completed up to August 2022 and did not reflect all the incidents that had occurred before and after this date. This meant, risks were not sufficiently identified regarding the persons behaviour and the impact of this on them and other people. Consequently, effective processes were not introduced to minimise risks and the impact of these on the people who live at the service.
- The governance system established to give assurance of the quality of service and to identify areas that required improvement was not effective. For example, we requested copies of the previous two driving up quality (DUQ) audits for the service. (DUQ are monthly audits which staff told us, were completed on the 5th of each month). A hand-written DUQ was provided for March 2023, however, the infection control section of the DUQ was not completed. There was no DUQ available for January or February 2023. This meant the system to oversee and audit quality was not effective.

Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There had been a recent change in manager at the service and an interim manager was in post while recruitment was on-going. The interim manager had been in post for approximately 6 weeks at the start of the inspection. The interim manager was also the service manager for another local Achieve Together service and was therefore working across two sites. Changes had been made to the service since the interim manager took up post and they had developed an action plan, with support. This was being worked through.

● The interim manager was working to make the culture more open and putting governance structures in place. For example, we saw documents that showed staff were reminded to ensure the manager was made aware of any changes to staff on shift, so the manager could be assured that people with the correct level of training were on the rota.

● When the manager was not at the service, it was led by lead support workers. However, the service had an on-call system to support staff whereby there was a service manager or the registered manager available to attend.

● Staff spoken with told us they felt supported by the interim manager. They told us they felt able to raise concerns with the interim manager.

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 interim manager understood duty of candour and the need to be open and transparent when things go wrong.

● There was a culture within the service of not recognising incidents as safeguarding concerns and therefore alerts were not appropriately made and the required statutory notifications were not consistently made to CQC. Although the provider had processes in place for reporting and investigating incidents, these processes had not been duly followed.

Continuous learning and improving care; Working in partnership with others

● The governance processes established by the provider were not used to effectively safeguard people and improve their care.

● Required statutory notifications regarding safeguarding incidents and accidents were not consistently made.

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 Systems had not been established to ensure care and treatment was provided in a safe way for service users. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established to protect service users from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice served.