Autism Care (Bedford) Limited

Autism Care UK (Bedford)

Inspection report

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Date of inspection visit:
26 July 2021
10 August 2021

Date of publication:
09 December 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Autism Care UK (Bedford) is a residential care home providing personal and nursing care to up to nine people with Autism or Learning Disabilities. At the time of the inspection eight people were living at the service.

The service supports people living in individual bedrooms with ensuite facilities as well as self-contained flats where people have their own kitchens and bathrooms. There are also communal areas available for people to use.

People's experience of using this service and what we found
Not all people living at the service felt safe to be there due to the behaviours of other people. One person told us, " I don't feel safe to walk past [the person] in the corridor but I have to. That is why I want to move." Staff told us another person had become quite isolated due to experiencing aggression from others.

People were not safeguarded from the risks of fire. We identified a fire risk at the service due to faults with fire doors and other doors being propped open.

Staff had not supported people to ensure their home was clean or well maintained. People lived in an environment that required redecoration and repair and had ingrained dirt on skirting boards, walls and doors in the communal spaces. The provider has since taken action to address these concerns.

People's medicines were not safely administered or managed and there were errors that had not been identified and addressed by the registered manager.

People were supported by staff who did not have the right level of knowledge and skill to meet their needs in relation to communication and helping them to manage anxiety.

Care records and risk assessments to offer staff guidance about how to support people safely were complex, duplicated and confusing. Staff told us they did not always understand them.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led, the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

People's mental capacity had not been correctly assessed in a meaningful way and there was no evidence of involving the person or others. There was also no evidence of deprivation of liberty safeguards applications having been approved.

The culture within the service was not person centred and documentation for goals and choices was standardised, often using the same wording across multiple assessments and multiple people. There was no evidence that goals were reviewed, and outcomes were not recorded. Two people had regular and increased incidents and staff thought this was due to not being able to regularly access community activities. Staff had used threats of depriving access to community activities as way of controlling one person's behaviour. There was a lack of effective monitoring and management of the service and people, staff and relatives told us the registered manager was rarely at the service.

The provider has been made aware of the areas of concern identified during this inspection and intend to begin addressing the areas for improvement.

As a result of our findings during this inspection we have made three separate safeguarding referrals to Bedford Borough Council adult protection team and informed Bedfordshire Fire Service of our concerns, who are following their own enquiries.

We have made a recommendation about staff recruitment records and processes.

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 21 February 2019).

Why we inspected
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.

We received concerns in relation to the management of risks rising from people's health conditions and support needs. We also had concerns about the general management and effective running of the service. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

The provider has arranged additional training for staff and put an action plan in place to address other concerns in relation to infection prevention and control, cleanliness of the environment, maintenance of the internal and external environment, COVID-19 safety and fire safety.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Autism

Care UK (Bedford) on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to cleanliness, fire safety, the management of COVID-19 risks and maintenance of the environment. We have also identified breaches in relation to the dignity and respect of people living in the service, a lack of individualised care and a lack of staff training to ensure suitable skills.

Additionally, we identified a lack of effective management and quality assurance systems, poor communication, no evidence of consent and care records that did not offer clear and effective guidance for staff.

We have imposed conditions on the provider's registration to drive improvement in the areas of concern highlighted above and promoting the principles of the right Support, right care, right culture policy.

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 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Autism Care UK (Bedford)

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Autism Care UK (Bedford) is a 'care home'. People in care homes receive accommodation and nursing or 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 registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch Bedford and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us 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 spoke with five people who used the service and six relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, regional director, deputy manager, team leaders and care workers. We spoke with five professionals who regularly visit the service.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. 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.

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

- Systems and processes to safeguard people from abuse such as policies, risk assessments and guidelines were not effective. Staff did not always understand them and the registered manager did not monitor them to ensure people were protected from the risk of harm.
- While staff had received training in abuse awareness and safeguarding, not all staff understood how to report concerns outside of the organisation. There was a lack of understanding by staff and management about the use of restrictive and punitive measures to control people's behaviour. One staff member had used a threat of restricting activities against a person on two occasions, as a way of controlling the person's actions. This had resulted in an escalation of anxiety related behaviours and the increased administration of sedative medication.
- There was no evidence the registered manager had reviewed and analysed relevant documents when incidents or serious medicine errors had occurred. The registered manager and provider were unable to locate incident forms and medicine administration records we requested. Not all safeguarding incidents had been reported to the Care Quality Commission.

We found evidence that people had been harmed in the form of psychological abuse, causing unnecessary anxiety and sedation. Systems were not robust enough to demonstrate people were kept safe. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- People's risks had been assessed; however, these were documented in up to three different formats which staff told us they found confusing. The risk assessments did not evidence any outcomes for follow up actions such as referrals to Speech and Language Therapists (SALT).
- The risk assessment booklets did not contain clear guidance for staff on how to safely manage those risks. Instead, they contained generic statements such as 'staff to support [person] with shopping'.
- People had specific plans for supporting them to manage their anxiety. These plans are known as a positive behaviour support plan. We found the required information for these plans was split across different documents and was overly complex. For one person, at the point where their behaviour was deemed at a 'dangerous level', there were 41 bullet points of actions for staff to remember to do. This was not realistic, and staff confirmed they could not remember them. This meant there was no safe, consistent approach to managing the risks related to people's needs.
- A person assessed as requiring one to one staff support when in the community was encouraged in another person's risk assessment to travel together in the vehicle. This meant they were sharing just two staff between them. The second person was assessed as requiring 2:1 staff support when in the community.

This meant should they need to stop due to an accident or health or comfort need, there would not be enough staff present to safely support both people.

● Faults in relation to fire doors and fire safety identified in a fire service report in August 2020 had still not been addressed at the time of the inspection. This placed people at serious risk of harm in the event of a fire.

● People's personal emergency evacuation plans had duplicated information across three people's plans in relation to their needs and how they would likely respond in the event of a fire. This meant it was not clear what information was related to which person.

● Medicines were not administered safely. There were numerous gaps of signatures on medicines administration records, and no evidence to show this had been followed up to determine if medicine had been missed. One of the gaps was for an anti-convulsant medicine for epilepsy which could have had a serious impact on the person if missed.

● There were confusing protocols for sedative medication used on an 'as needed' basis. This medicine should be used as a final option in the event people's behaviours became dangerous for them. One person's protocol suggested three doses per 24 hours with a 12-hour gap between doses. Another protocol stated no more than one dose in 24 hours but other documentation in their file stated they could have a second dose after 30 minutes. This medicine, if not used correctly, can cause breathing difficulties.

● There was a misuse of this medicine as behaviour charts showed that it was administered within five to 10 minutes of a person becoming anxious and before other options had been tried. On one occasion, one person was administered this medicine three times in an eight-hour period placing them at serious risk of respiratory difficulties. This had not been identified or reported by the registered manager.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The lack of adequate fire safety measures was also a breach of regulation 15 (Equipment and Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to the identified fire safety related risks. They confirmed all the actions from the fire risk assessment were now being completed and suitable checks of the environment and equipment were in place. Bedfordshire Fire Service confirmed fire status was now satisfactory but not fully compliant. The service have been given an action plan which the fire service will review in one month.

● The provider did ensure servicing checks had been completed on fire and other equipment in the service.

● Staff did undertake regular testing of fire systems and had reported the damage to the fire doors, but action had not been taken.

Preventing and controlling infection

● We were not assured that the provider was using personal protective equipment (PPE)effectively and safely as staff were seen to be wearing the incorrect type of mask and did not wear them correctly covering their nose and mouth. No clear masks had been sought to support people who were deaf.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. This was because the environment was very dirty in communal areas. The laundry room floor only had floorboards that could not be washed and disinfected. Sealant around a toilet sink was hanging off and dirty. These all added to an increased risk of the spread of infection.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented

or managed. This was because staff training was not effective, and their knowledge and practice not assessed for competency except for handwashing. The provider sought to use the same agency staff for continuity of care and to reduce cross contamination across services. However, this was not always possible. Staff told us they did not feel supported if they had to isolate as a result of a COVID-19 outbreak as it affected their pay, which could be delayed by one month and the registered manager did not contact them to check how they were.

● We were not assured that the provider's infection prevention and control policy was up to date. The policy was dated October 2017 and did not include information about COVID-19 risk management. The provider sent a further COVID-19 specific policy after the inspection; however, this had not been updated since October 2020. Other information about COVID-19 guidance was sent to staff in the form of memos but not all staff understood these. There was no evidence of regular Infection Prevention and Control audits and those which were completed did not evidence outcome of actions.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections because visitors' temperatures and COVID-19 tests were being checked but no screening questions were asked.

● We were somewhat assured that the provider was meeting shielding and social distancing rules because the layout of the building supported shielding. However people and staff were not social distancing and not all staff were aware of how to safely isolate people in the event of an outbreak.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate the maintenance of the environment and prevention of the spread of infection was effectively managed. This placed people at risk of harm. This was a further breach of regulation 15 (Equipment and Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have signposted the provider to resources to develop their approach. The provider has since taken action to rectify all IPC concerns raised. However, this is a concern that will be ongoing while staff knowledge and practice is improved.

Staffing and recruitment

● Staff had received training relevant to their roles. However, this was mostly online and there had not been any follow up to check their understanding of how they applied their learning in practice. This meant there were not enough suitably trained and skilled staff to ensure people's needs could be safely met.

● Staff told us they did not feel confident to apply some learning and to work with some people. They also told us they did not understand some of the guidance in people's care records.

● There was little evidence of staff induction and staff told us they were not able to shadow more experienced staff or have specific training. Staff told us they had to 'learn on the job' to meet people's continence care needs and to learn how to safely use a wheelchair. Staff had also not received regular supervision and appraisals. For most staff members, their last supervision was over a year ago. Some staff told us they had never received an appraisal despite working at the service for several years.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has since offered more online training but there is not yet evidence of assessing staff competency and offering sufficient support for staff to develop their practice.

● There were recruitment and selection processes in place which ensured appropriate checks were made prior to employment. There were some gaps in employment history. It is important that all gaps are followed up and explanations checked to ensure staff are safe and suitable for the role.

We recommend the provider consider current guidance in relation to staff recruitment processes and requirements and take action to update staff records accordingly.

Learning lessons when things go wrong

● There was no evidence seen during the inspection of staff being supported to reflect on incidents when things had gone wrong, to look at ways of improving practice. However, following the inspection, the provider submitted one example of where staff had been supported to debrief by the deputy manager. Staff told us they did not get any support and even if they had been injured in the incident, there were no checks on their well-being by the registered manager and no opportunity to debrief.

● It is important for staff to be able to debrief and be given support in the event of an incident so they can learn from it without blame and so that resentment or intolerance for people does not develop. There was space on the behaviour chart for the registered manager to do this, but this was mostly left blank and unsigned or they had simply stated 'staff coped as per their training'.

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 deteriorated 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

- Staff did not all understand the requirements of their role and related legislation. Inappropriately completed and incomplete records demonstrated a lack of understanding of the fundamental needs of people they were supporting. This compounded people's anxiety and increased incidents of behaviours that may challenge others.
- We were told by people, their relatives and staff that the registered manager was often not at the service. There was no evidence that the registered manager had effective oversight of the needs of people and staff. Documentation that should have been signed off and reviewed by them had not been.
- Quality assurance systems had not identified the concerns we found during this inspection and actions that were identified had not been completed.
- Additional evidence from the provider to demonstrate their oversight showed the quality audits had also not identified the concerns we found, apart from the fire risks which had not been acted on in over one year. Most of the provider oversight relied on remote reports presented by the registered manager. Schedules for visits by senior managers showed they did not all happen as planned.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate quality of care and the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Mental capacity assessments and best interest assessments completed by the registered manager and used to determine if a person can make their own decisions or not, evidenced a lack of understanding of the principles of the Mental Capacity Act. Some paperwork had the wrong person's name on it or referred to a male as 'she' and multiple records had the exact same wording copied across. Records reviewed by inspectors were often not dated or signed. Following the inspection, the provider told us paper versions of the records did have dates and signatures added.
- There was no evidence of involving people or how they were supported over time to understand the decision being made. There was also no evidence of others in the person's life such as relatives or health professionals being involved. This would be best practice to ensure fair decisions that are the least restrictive option to keep the person safe were made.
- There was no evidence of an approved DoLS application for any of the mental capacity and best interest assessments that had been reviewed during the inspection. Following the inspection, the provider showed

evidence of an approved DoLS for one person for the purpose of care and treatment. The registered manager did submit to the commission, two applications for DoLS that were waiting approval for two people but there was no evidence of a mental capacity assessment having taken place for these.

Failure to ensure appropriate approval and processes were sought for depriving people of their liberty was also a breach of regulation 11 (Consent) 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

● A person-centred culture was not promoted by the registered manager or provider. Documentation and goals were standardised and had the same goals across several people rather than working with a person to agree what they would like to work towards. Steps to achieve the goals were brief and generic and did not offer support or guidance as to how a person might achieve them. There were no reviews demonstrating outcomes and they were often not dated or signed.

● A professional who worked regularly with the service told us staff had not understood how to support a person with a goal around healthy eating and lifestyle change and so, they did not support it.

● Care plans stated that people were not able to be involved because they would not understand. This contradicted statements in goals where they were to be asked questions about their medicines or finances. Care records, staff and the registered manager referred to people by the acronym 'PWS' (person we support) rather than their preferred names.

● One person used British Sign Language as their first language. However, most staff had not received training in this and those who did told us it was so long ago they could not remember it. The person could also use Makaton (a system of signs, speech and symbols) but only a few staff were confident in using this. They were able to write but found they were unable to communicate fluently or fully using the written word. Staff told us the person was becoming more isolated as a result and rarely left the house.

● One professional told us they understood the service had recently gone through a lot of change and there were a few individual staff who could be very good, but that many staff lacked awareness and their approaches were not personalised, creative or pro-active. They went on to say, "[Staff] are not always strong on agreed approaches to take and need a lot of 'hand holding'. They have needed a lot of external support."

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate how individualised care was being supported. This placed people at risk of harm. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two people had portable listening monitors in their flats; this is a deprivation of a person's liberty. An application for depriving a person of their liberty, has to be authorised by the local authority. There was no evidence of this being approved and the receiver was in the upstairs lounge with staff. This meant people's privacy was not upheld as other people, staff or visitors in the lounge area could hear what was happening or being said in the flats.

● The first-floor lounge was full of staff lockers, PPE stocks, parcels and office chairs, and did not offer a homely environment tailored to the preferences of the people living there.

The failure to ensure people's dignity and privacy were upheld was also a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

characteristics

● People told us the registered manager did not ask their views about the care and they felt they were not listened to. They told us, "Sometimes the staff don't listen. I just go again and keep going to them until they listen and at the end, they do listen the third or fourth time. I don't like it, but I just wait."

● One relative told us, "No contact at all from the registered manager, I have only spoken to them once when they first started and [My family member] had gone to hospital. They said they would call back in the morning and never did."

●However, people, staff and relatives felt the deputy manager was very good and was trying to improve the service. They all felt they could speak with the deputy manager. One relative gave an example of how they had been waiting for two years for redecoration of their family members room. After speaking with the new deputy manager, it was arranged for one months' time.

● Relatives' feedback was mixed. Some relatives felt the staff were doing their best and their family members were happy. Some relatives told us they were not listened to. The provider asked relatives to complete an anonymous survey annually. However, relatives told us, they never received a summary of the key themes from the survey or what action the provider had taken as a result of their feedback.

● Other relatives felt concerned about the lack of engagement and staff skills to meet the needs of their family member. All relatives had strong concerns about the lack of continuity of management, the number of manager changes and the registered manager often being absent . All relatives told us the communication with the registered manager and senior managers was very poor.

● Relatives said they were involved in reviews but only ones led and arranged by the local councils.

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 registered manager did not demonstrate an understanding of their duty of candour. Safeguarding incidents had not been identified or reported and relatives told us when things had gone wrong, they were not always informed. One relative told us the registered manager had promised to call back with information but had never done so.

● The service did display their most recent inspection rating on their website and in the service.

Continuous learning and improving care

● There was no evidence of continuous learning in the service. The provider had been reactive in responding to concerns raised by the CQC during the inspection and had taken action to address them. However, they did not have effective systems in place that identified these concerns for themselves.

● Staff told us they were not given the opportunity to reflect and discuss how to improve the service and any suggestions they tried to make were not listened to or acted upon.

Working in partnership with others

● Professional feedback was mixed. Some professionals felt the service ran well with no concerns in relation to the aspect of care they were responsible for. One professional told us the staff team have been responding well and mostly doing what they needed to do. They felt things had started to improve in the last six months and had no concerns.

● Other professionals were concerned about the lack of managerial oversight and staff training and support. One professional told us the staff did not appear to be supported or to be able to think through simple strategies for managing behaviour that may challenge.

● There was evidence in people's records of staff contacting various health professionals when required.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not supported in ways that upheld their dignity and respect. Listening devices meant there was no privacy for two people. People were referred to by acronyms instead of their preferred names.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and risk of fire safety.

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 9 HSCA RA Regulations 2014 Person-centred care Care was not person centred. Goals and activities were standardised, brief and did not evidence any involvement of people, their advocates, relatives or health professionals. People were not supported with meaningful activities.

The enforcement action we took:

Notice of Proposal to be served imposing positive conditions including for Right Support, right care and right culture.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have their rights to consent to their care and support respected. Restrictions were in place without proper assessment of their mental capacity. Best interest processes were not carried out appropriately and there was no evidence of approved deprivation of liberty safeguards.

The enforcement action we took:

Notice of Proposal to be served imposing positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not supported safely with medicines nor with the management of their behaviours.

The enforcement action we took:

Notice of Proposal to be served imposing positive conditions

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 People were not protected from the risk of harm. Use of threats (psychological abuse) and serious medicine errors had not been identified by the provider or reported to the relevant authorities. Some staff were not aware of how they could report concerns external to the provider.

The enforcement action we took:

Notice of Proposal to be served imposing positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had little oversight of the service and quality assurance systems were not effective in identifying concerns. The provider oversight was also not effective and action plans did not drive improvement or result in positive outcomes for people.

The enforcement action we took:

Notice of Proposal to be served imposing positive conditions and to include the condition for the provider to produce and submit a regular action plan to the commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have the training and skill to ensure they could fulfil the requirements of their role and safely met the needs of people living in the service. Staff competency was not assessed.

The enforcement action we took:

Notice of Proposal to be served imposing positive conditions