Portland Care 3 Limited

Wood Hill House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Wood Hill House is a care home that provides accommodation, nursing, and personal care for adults. People living in the home had a range of care and support needs including people living with physical disabilities, mental health needs, learning disabilities, and autism. The home can accommodate up to 83 people in one purpose-built building over 4 floors. At the time of this inspection there were 13 people residing at Wood Hill House.

People's experience of the service and what we found:
People's medicines were not always managed safely. There were environmental safety concerns in the building which placed people at risk of harm. Safety concerns identified through risk assessment were not acted upon, therefore we could not be assured the risk had been mitigated. Plans to support people with safe evacuation in the event of a fire were not detailed and did not reflect advice from the fire and rescue service. There were policies and processes in place for managing safeguarding concerns, however we found concerns were not always identified by managers reviewing incidents. There were enough staff to meet people's needs.

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. The provider did not work in line with the Mental Capacity Act. Not all people had capacity assessments and best interest decisions where a need was identified. There were delays in applications for Deprivation of Liberty Safeguards (DoLS) authorisation. The system in place for monitoring DoLS applications, authorisation, and conditions was ineffective. A significant number of the staff team had not completed mandatory training. Staff did not have up to date training or competencies to meet complex health needs including tracheostomy, Percutaneous Endoscopic Gastrostomy (PEG), and catheter care. Not all staff had received supervisions or appraisals as per the provider's policy.

We found care plans lacked person-centred detail. Some positive behaviour support plans had not been devised for people where there was an identified need. The service was not meeting the Accessible Information Standard. There was a lack of support for people to access meaningful activities. Managers were working to improve this, however, did not audit or have oversight of what activities were taking place.

Systems for identifying, capturing, and managing organisational risks were ineffective. The provider did not have a clear and consistent system of audit in place. The provider had not fully acted on feedback from professionals for continually evaluating and improving the service or for assessing, monitoring, and mitigating risks to the safety and welfare of people. Staff told us managers were making improvements and felt there was an open and positive culture.

We received mixed feedback from people about the care they received. There was no system in place to seek feedback from people about their care. Our observations of care provided were positive. Staff spoke

passionately about the support they provide for people. There were enough staff to meet people's needs.

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. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

The service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture. These principles were highlighted as not being met at the time of the last inspection and we found minimal improvements had been made to the clinical environment and lack of personalisation. Managers told us work was ongoing to reduce occupancy from 83 to 42 people. We found the size, scale, and design of the current and future premises compromise quality of care and does not facilitate person-centred care. The provider had not carried out any audit or benchmarking against right support, right care, right culture to show how the service meets the needs of people in line with this current best practice. Audits in place were not fully checking whether the service was meeting the principles within the guidance: the size, setting, and design; community participation and having the right model of care; and policies and procedures. Managers told us work was ongoing to implement an audit, however we did not receive this as part of information requested following the inspection.

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 the service under the previous provider was good, published on 10 July 2021.

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

Enforcement
We have identified breaches in relation to person centred care, need for consent, safe management of medicines, the premises, governance, and staffing. As a result of concerns found at this inspection we served Warning Notices and a Notice of Proposal. The provider submitted representations against this proposal and following review of these representations, a Notice of Decision to impose conditions was served. This was not appealed by the provider. Therefore the conditions placed on the provider's registration mean that they cannot provide regulated activities to anyone with a primary need of a learning disability and/or autism at Wood Hill House.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well-led findings below.	**Inadequate**

Wood Hill 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.

Inspection team
The inspection team consisted of a senior specialist for people with learning disabilities and autistic people, an inspector, a medicines inspector, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Wood Hill 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. Wood Hill House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post. The provider assured us additional support from the operations manager was in place in interim and the manager intended to re-submit their application for registration.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
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. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, clinical commissioning group, and Healthwatch. 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 all this information to plan our inspection.

During the inspection
We spoke with 10 people who lived at Wood Hill House about their experience of the care provided. We met with the manager, deputy manager, and operations manager. We spoke with 10 members of staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked around the building to check environmental safety and cleanliness. We looked at written records including 3 people's care records and 2 staff files. We spoke with a visiting professional. A variety of records relating to the management of the service were also reviewed. After the inspection we continued to seek clarification from the provider to validate evidence found. This included policies and procedures, supervision and training data, and audits.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
•People were not supported to receive their medicines in a safe way. Some people's health was placed at risk of harm because their medicines were unavailable or out of stock. One person did not have their prescribed nutritional supplement for a week because there was no stock in the home.
•Medicines were not always given safely because the manufacturers' instructions were not followed properly. People were given medicines which should be given before food at the same time as medicines that needed to be given after food, which meant the medicines may not have been effective or avoidable side effects could have been experienced.
•Medicines which were prescribed to be given 'when required' (PRN) or with a choice of dose did not always have a protocol in place to guide staff how to administer these medicines consistently and safely. When protocols were in place, they did not always have enough personalised information in them. When PRN medicines were given the effectiveness of the medicines was not always recorded or was not recorded in a timely manner.
•The records about the quantity of some medicines in stock were not always accurate, and could not show that medicines had been given as prescribed or could be accounted for. One person missed having their eardrops administered for several days because there was no record to show the drops were in stock. Records about bowel monitoring did not always record enough detail to help staff decide if laxatives were required. People who had swallowing difficulties and were prescribed a thickening agent to add to their drinks. Staff making drinks failed to make records when they added prescribed thickener to drinks and this meant it was not possible to tell if people's drinks had been properly thickened.
•Information from a pharmacist about how to administer medicines safely via a percutaneous gastric tube was missing. One person was given eye drops which were out of date.
•Waste medicines were not stored safely in line with current published guidance.

Although we found no evidence that people were harmed at the time of the inspection because the harm is not always immediate, however, people were placed at increased risk of harm by unsafe management of medicines. The provider failure to ensure safe systems for the management and administration of medicines was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
•The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks. We found environmental safety risks in the service including a leaking kitchen ceiling where water was coming through the electrics. We found this concern had been identified in a fire risk assessment carried out 12 April 2023. Building checks also identified where fire doors were damaged

compromising fire safety, and emergency lighting required maintenance or replacement. There were work men on site, however none of the works required had been completed at the time of our inspection.
•Person Emergency Evacuation Plans (PEEPs) lacked detail and did not always reflect people's current needs. Plans did not detail how staff should support a wheelchair user or person with low motivation to evacuate in the event of an emergency.
•Advice from South Yorkshire Fire regarding a system for safe evacuation in the event of a fire was not reflected in PEEPs.

The failure to ensure all premises and equipment used by the service provider were clean and secure. This is a breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and avoidable harm; Learning lessons when things go wrong
•The provider had not always learned lessons when things had gone wrong. One incident reviewed by the manager did not identify a possible safeguarding concern. We raised this with the manager during inspection and they confirmed a retrospective safeguarding referral would be made.
•We identified a need to meet the principles of right support, right care, right culture at the time of our last inspection and while engaging with the provider. The provider was not benchmarking against these guidelines.
•People were not always safeguarded from abuse and avoidable harm. Staff spoke confidently about safeguarding people and there was evidence of safeguarding concerns reported to the local authority. The manager had a system of review for safeguarding incidents and referrals, however did not analyse the information to identify themes or trends.

Staffing and recruitment
•The provider did not always operate safe recruitment processes. We found one staff member newly recruited did not have a professional reference from their most recent previous employer.
•Interview templates used for recruitment did not include questions relating to understanding of learning disability, autism, or safeguarding.
•The provider ensured there were sufficient numbers of staff. Staff and managers told us they had ample staff to meet the needs of the service. Bank staff familiar to the home were used to cover any sickness or absence.

Preventing and controlling infection
•People were protected from the risk of infection as staff were following safe infection prevention and control practices. The majority of staff were trained in preventing and controlling infection and had access to personal protective equipment (PPE).
•People who used the service and their relatives did not report any concerns relating to cleanliness or hygiene.
•People were able to receive visitors without restrictions in line with best practice guidance. One relative told us "The staff are so friendly I feel like I'm going to a friend's house". Another relative told us when they visit the staff do not answer the door or call bell, this has meant they no longer visit on weekends, as they find it, "Too difficult to get in."

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS).

The provider did not work in line with the Mental Capacity Act.

•Some mental capacity assessments and subsequent best interest decisions had been completed. These did not evidence the two-stage test for capacity and the best interest checklist around whether a particular decision was in that person's best interest. These assessments lacked detail around how people were supported to understand the information required to make the relevant decision.
•CCTV was in use in the building's common areas however, not all people had an active capacity assessment or best interest decision relating to the use of CCTV. The manager told us no additional support or visuals had been provided to explain the presence of CCTV to people.
•Staff failed to complete capacity assessments prior to requesting the standard DoLS authorisation for several people. There was no information on the practical and reasonable steps taken to avoid a deprivation of liberty record on the DoLS tracker, in relevant sections of the care plan, or in the authorisation request.
•One of the care plans did not accurately reflect when a person was on a standard DoLS authorisation or the conditions attached to inform and guide staff on the legal restrictions in place.
•The completed tracker system to monitor appropriate deprivation of liberty authorisation did not correctly reflect the conditions or expiry dates on the standard DoLS authorisations for some people.
•Staff were not requesting further standard DoLS authorisations in a timely manner.

The failure to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
•The management team did not ensure staff had the skills, knowledge and experience to deliver effective care and support. There were significant gaps in training compliance across the staff team. There were 10 mandated face to face training sessions including moving and handling, positive behaviour support, choking, hydration, and first aid at work. Of these, 9 training sessions showed extremely poor uptake levels by staff.
•The manager could not provide evidence of training or competencies for additional needs including percutaneous endoscopic gastrostomy (PEG), tracheostomy, or catheter care. We found staff supporting a person with tracheostomy needs did not have up to date training or competencies in place. Staff competencies were out of date or not available to view. This included medication, moving and handling, PEG, tracheostomy, and catheter care.
•Staff were not fully trained in how to interact appropriately with autistic people and people who have a learning disability in order to provide person-centred care. Only 45% of the staff team had completed the Oliver McGowan training requirement, with a further 4% marked at in progress.
•Staff told us they did not always have time or the required technology to complete training while on shift.
•The Supervision Policy and Procedure noted a required frequency of 6 supervisions for staff per annum. The manager provided a supervision tracker which showed the majority of staff had only received 2 supervisions in 2023. According to the supervision tracker 9 staff had not received any supervision. The manager did not have oversight of any appraisals.

The failure to ensure staff had up to date training or competencies was a breach of regulation 18(2) 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; Staff working with other agencies to provide consistent, effective, timely care
•People's needs were not always assessed, care and support was not always delivered in line with current standards. People did not always achieve effective outcomes. Care plans did not contain consideration for the desired aspirations or end-goals for each person. Care plans did not identify short-term or long-term planning or goals in terms of developing a person's activities of daily living, interests, or working to live more independently.
•Care plan reviews had not taken place for all people. Some reviews conducted involved family members or advocates.
•The provider ensured the service worked effectively within and across organisations to deliver effective care, support and treatment. Staff made referrals to healthcare professionals when people's needs changed. This included the GP and community mental health teams.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
•People were not always supported to live healthier lives, access healthcare services and support. Care plan information was inconsistent regarding Speech and Language Therapist assessed needs, fluctuating between different levels of food and fluid preparation.
•People were supported to eat and drink enough to maintain a balanced diet. Care records reflected regular recording of fluid intake for people. Managers carried out daily review of fluid intake records for people at risk, however the information did not specify whether people were meeting their daily recommended intake of fluid.
•There was no system in place for involving people in meal planning.

Adapting service, design, decoration to meet people's needs
•People's individual needs were not met by the adaption, design and decoration of the premises. We found

the physical environment in the homes to be clinical, bare, and in significant disrepair. Evidence of maintenance work required throughout the building included holes in walls exposing insulation, wallpaper peeling off walls, a bath coming away from the wall with exposed pipe work, missing toilet seats, and drawer fronts missing from wardrobes. The manager had not acted on these issues.

•Fob locks on doors to the home and key codes on elevators meant all people were subject to a blanket restriction. Staff told us some people required locked doors as they would not be safe accessing the community without staff support, however this was not the case for all residents. The manager told us they were working on sourcing key access for people who requested it.

•One floor of the building was undergoing renovations. The manager told us people had been consulted regarding the renovations in informal verbal conversations. People who do not communicate verbally were not consulted, involved, or informed about renovations to the building.

•The outdoor space to the rear of the building was visibly dirty with litter and debris scattered throughout.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
•People were not supported to express their views and make decisions about their care. There was no formal system in place to gather feedback from people about the care they receive. The manager carried out informal ad hoc conversations with people who communicated verbally, however did not have a system in place to gather feedback from people who do not communicate verbally.
•The manager had a plan to implement residents' meetings, however none had taken place or were scheduled.

Ensuring people are well treated and supported; respecting equality and diversity
•People were not always well supported and treated with respect by staff. We received mixed feedback from people. Some responded positively when asked about their support from staff, 1 provided constructive criticism, and 2 people told us they were not happy living in the home. We escalated concerns received to the manager.
•We carried out a SOFI that highlighted consistent positive interactions between staff and residents.
•Staff spoke passionately about support for people. One staff member told us, "I take pride in making them happy." Another staff member said there was a, "Sense of love and sweet interaction between staff and people."

Respecting and promoting people's privacy, dignity and independence
•People's privacy, dignity and independence were not always respected and promoted. Care plans and daily notes lacked detail around how people were working toward maintaining or building independence. There was no kitchen, cooking facilities, or laundry available to people to enable them to maintain existing skills and learn new daily living skills.
•Staff spoke respectfully to people and we observed staff interacting with people in good humour.
•One person told us, "I do get a say, they ask me what I want."
•One person had been supported with medication management in order to safely go on holiday independently.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has 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
•People were not always supported as individuals, or in line with their needs and preferences. We found that care plans lacked detail and were not person-centred. Managers carried out audits of care plans which identified similar shortfalls but had not changed them.
•Not all people had positive behaviour support plans where there was an identified need. Positive behaviour support plans lacked information around detailed individualised positive strategies to reduce a person's distress.
•People were not involved with and did not co-produce their care plans. When asked if they had a care plan a person said, "I might do but I've never seen it." and, "[Staff have] done my care plan for me."
•Care plan information for 1 person was not specific enough around when 1:1 support is required. During our inspection we found this person was not always supported on a 1:1 basis contrary to their care plan.

The failure to design care or treatment with a view to achieving people's preferences and ensuring their needs were met was a breach of regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs; Improving care quality in response to complaints or concerns
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 provider was not meeting the Accessible Information Standard.
•People's communication needs were not understood or supported. Staff relied heavily on verbal communication and told us this was how they communicated with people. Staff were trained in basic sign language, however we did not observe it in use throughout our inspection process.
•One person had a condition on their DoLS authorisation detailing a picture exchange communication system was to be developed and used to aid communication. We found there was no such system in place and staff communicated with this person verbally.
•People's concerns and complaints were listened to, responded to and used to improve the quality of care. The manager tracked complaints and evidenced where action had been taken as a result, however there was no formal system in place to gather people's feedback. We were not assured the provider had an accurate understanding of concerns.

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 not always supported to maintain relationships, follow their interests or take part in activities that were relevant to them. There was a lack of meaningful activities available to all people to enable them to lead meaningful and fulfilling lives. Over a 6 week period there were only 5 community based activities recorded, not all people had been supported to access meaningful community based activities within this timeframe.
•The manager identified a need to increase meaningful activities for people and provided examples of recent trips to aquariums and bowling. There was no regular oversight for managers to understand the amount, type, level and quality of meaningful engagement and activities made available.

End of life care and support
•People were supported at the end of their life to have a comfortable, dignified and pain free death. Care plans included specific end of life information for all records we reviewed. One person's end of life care plan had been updated without their involvement or input from their family.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were 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; 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 did not have a fully supported management structure. The provider's system did not always effectively monitor the quality of care provided to drive improvements.
•Systems for identifying, capturing, and managing organisational risks were ineffective. The provider did not have a clear and consistent system of audit in place. The manager did not have oversight of staff training, competencies, safeguarding, or accidents and incidents. The provider confirmed they are beginning to record this information within spreadsheet formats however, were not reviewing the information to identify any potential actions, themes, or trends.
•The manager was not yet registered with CQC. The provider assured us they would support them to submit an application to register.
•The provider did not have appropriate systems and processes to ensure CQC were notified, as required, about the outcome of relevant standard authorisations for DoLS without delay.

The failure to assess, monitor, and improve the quality and safety of the services was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The provider understood their responsibilities under the duty of candour.

Continuous learning and improving care
•The provider had not consistently created a learning culture at the service which meant people's care did not always improve. The provider had not acted on feedback for the purposes of continually evaluating and improving the service. The environment was not homely with corridors and communal areas stark with no decoration. This was despite similar concerns identified at the last inspection.
•The last inspection identified the premises looked clinical and were not personalized to reflect individual people. The provider had made some small improvements, however the environment remained clinical and lacked personalisation overall.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
•The provider did not always have effective systems to provide person-centred care that achieved good outcomes for people.

•There was a positive and open culture at the service. Staff spoke about the positive culture in the team. They consistently reflected that recent changes to the management team have been welcome and beneficial.
•Staff described the management team as, "Very supportive, able to help us with anything we need from them."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People and staff were not involved in the running of the service and their protected characteristics were not well understood. The provider did not have a consistent approach to sharing information with and obtaining the views of staff, relatives, or people.
•Some meetings with relatives took place. One relative told us, "I feel they would listen to any concerns."
•Staff told us they felt listened to by the management team. One staff member said, "I would have no hesitation raising something again should I need to. The manager is excellent, the door is always open."

Working in partnership with others
•The provider did not always work in partnership with others. The provider had not fully acted on feedback from other professionals for the purposes of assessing, monitoring, and mitigating the risks to the safety and welfare of people.

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
Treatment of disease, disorder or injury	The failure to design care or treatment with a view to achieving people's preferences and ensuring their needs were met was a breach of regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Notice of Decision to impose a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The failure to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Notice of Decision to impose a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Although we found no evidence that people were harmed at the time of the inspection because the harm is not always immediate, however, people were placed at increased risk of harm by unsafe management of medicines. The provider failure to ensure safe systems for the management and administration of medicines was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Warning Notice. We asked the provider to become compliant in 3 months.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The failure to ensure all premises and equipment used by the service provider were clean and secure. This is a breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Warning Notice. We asked the provider to become compliant in 3 months.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to assess, monitor, and improve the quality and safety of the services was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Notice of Decision to impose a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure staff had up to date training or competencies was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Warning Notice. We asked the provider to become compliant in 3 months.