Lifeways Inclusive Lifestyles Limited

The Dukes House 3

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
The Duke's House 3 is a residential care home providing accommodation, support and personal care to three people who have a learning disability, autism or a mental health support need. The service can support up to six people. The home is a three storey Victorian building, in a residential area of New Brighton. Each person has an en-suite room; and there were communal areas.

The Duke's House 3 shares the same staff team, management team, outdoor space, office and many other systems with the providers location The Duke's House which is next door. We inspected both services at the same time; specific information regarding The Dukes House is reported in a separate report.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. Registering the Right Support, ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

The service was next door to another location provided by Lifeways Inclusive Lifestyles. To the public they look like and in many aspects operate as one care home; between them can accommodate up to 14 people. This is larger than current best practice guidance. In some ways this was mitigated, for example; there were no identifying signs to indicate it was a care home and staff were discouraged from wearing anything that suggested they were care staff when coming and going with people. However, in other ways the care home was in contrast to the surrounding homes. For example, the three front gardens had been converted into one large car park, there were large gates across all entrances and there were no bay window coverings and when the lights were on the public could see into people's communal areas from the street.

People's experience of using this service and what we found
Staff were caring in their interactions with people and it was evident that staff endeavoured to have positive relationships with people. Whilst staff as individuals had a caring approach towards people; the provider had not developed, promoted or ensured that there was a caring culture at the home that respected and enabled people.

The home had a very restrictive environment. The provider had taken depriving people of their liberties for granted and had not ensured that people's fundamental rights were acknowledged and protected.

The systems in place for assessing, monitoring and managing risks when supporting people were inadequate. They had not always ensured that the use of restraint had been safe and effective. This meant that important information regarding people's safety was not always available for staff.

People's risk assessments had not always been reviewed following a significant incident. The safe and

effective use of restraint had not always been reviewed after significant physical interventions. There was inadequate debriefing and learning from incidents; even when staff members told us that they had raised safety concerns about the management of incidents.

Staff had not always been effective in listening to a person's communication and actions. The culture at the home had not promoted staff being curious and exploring with them, what views or decisions they were communicating.

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 service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support. There were limited opportunities for people to develop skills and increase their independence. People' support plans were not focused on; and the design of the home's environment did not support this and promoted people's reliance on staff members.

Some aspects of the design and adaptation of the environment was not working for people. Some people had been supported to decorate and personalise their rooms; they told us that they liked their rooms. However, overall the environment of the home was not homely and was mostly bland, featureless and uninviting.

There were enough staff to meet people's support needs safely. However, staff had not received appropriate support and training to enable them to be effective in their role. The provider had not maintained their programme of training and refreshment training for staff.

The previous managers of the service had left. The home had a new deputy manager and a new manager who was in their induction period and was not registered with the Care Quality Commission. The provider told us that they were supporting the service during this period using managers from other areas of the organisation. However, the provider had not ensured that the home had a positive culture. Staff including senior staff told us that there had been a very negative culture at the home.

The provider had a lack of oversight of the safety and quality of the service being provided for people.

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 25 July 2018).

Why we inspected
The inspection was prompted due to concerns received about the leadership of the service from a whistle-blower and the police. A decision was made for us to inspect and examine any risks.

We have found evidence that the provider needs to make improvements. Please see the is the service safe; is the service effective; is the service caring; is the service responsive and is the service well-led sections of this full report. 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 identification and management of risks; including the provider ensuring as much as possible that people were safeguarded from the risk of abuse. The environment of the home and people's support not always reflecting their needs and preferences; at times people's support did not reflect what had been agreed in their support plan. People's records did not always demonstrate that their health needs had been met. The provider had not ensured that people's fundamental rights were acknowledged and protected.

Staff had not received appropriate support and training to enable them to be effective in their roles. The provider had not ensured that the CQC had been informed of all notifiable events; and the provider had not assessed and improved the quality and safety of the service provided for people.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

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

The Dukes House 3

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by an inspector and an assistant inspector.

Service and service type
The Duke's House 3 is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The registered manager had left the service. There was a newly appointed manager who had not applied to become registered with the CQC. This means that the provider is 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. 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 three people who used the service about their experience of the care provided. We spoke

with ten members of staff including an area manager, a manager who had been seconded to the service, the home manager, deputy manager, five support workers and a cook.

We reviewed a range of records. This included two people's care records and medication records. We looked at one staff file in relation to recruitment and staff supervision; along with a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate the evidence found in relation to training data.

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

- The provider's management of concerns that people may be at risk of abuse was not robust.
- For example, one allegation of abuse that a person had made had not been thoroughly investigated. The date and time of the incident and who was involved or may have witnessed it had not been explored. There was no evidence that the person themselves had been spoken with to gain more information or all staff members present at the time of the allegation had been spoken with. The investigator had made their conclusions that the significant allegation was unsubstantiated without conducting a full and proportionate investigation.
- Only 58% of staff had received their safeguarding training refresher in line with the providers policy.

The provider had not ensured as much as possible that people were safeguarded from the risk of abuse. 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; learning lessons when things go wrong

- The systems in place for assessing, monitoring and managing risks when supporting people were inadequate. Some risk assessments referred to by staff or in people's care plans did not exist; at times care plans referred staff to a risk assessment for more detail and the risk assessment referred them back to the care plan. This meant that important information regarding people's safety was not always available for staff.
- The providers systems had not always ensured that the use of restraint had been safe and effective. For some people there was a protocol that outlined specific, safe methods of restraint that staff could use as a last resort to keep people and themselves safe.
- The protocol in use by staff had not been dated; it stated that a review needed to be completed every four weeks whilst the restraint method was being used. There was no evidence that these protocols had been reviewed since June 2019.
- Staff told us, and completed records showed that at times staff deviated from this plan and the restraint used differed from what had been planned for. Staff also told us that the planned restraint was not always safe as often it was needed in places where there was not enough room for it to be completed safely.
- At times documents showed that staff had restrained people when they had not received the training to ensure that they did so safely.
- It had been identified that a number of people could not identify dangers within the home's environment; or could use aspects of the home's environment to self-harm. However, there were no individualised risk assessments highlighting these particular risks and how these should be managed by staff.

● Specific risks to staff had not been addressed or managed appropriately. This had meant that some staff had not felt safe and supported in their role. One senior staff member told us that in his opinion the service provided for people had at times been unsafe.
● The provider had not ensured that serious incidents were reviewed, leading to improvements in the support provided for people. Incident forms were completed by staff; however often these were not fully completed. Incidents forms were not numbered as directed, so senior staff could not be sure they had seen them all. One staff member had told us that, "Incident report forms seem to lead to no action being taken."
● People's risk assessments had not always been reviewed following a significant incident. The safe and effective use of restraint had not always been reviewed after significant physical interventions. There was inadequate debriefing and learning from incidents; even when staff members said told us that they had raised safety concerns about the management of the incident.
● The providers recording system for incidents was incomplete and did not contain information of all the incidents that we reviewed.

The inadequate assessing, monitoring and managing of risks placed people at risk of harm and was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The provider had a system in place to support staff to administer people's medication safely as prescribed. People's medication had been mostly managed safely; however, there were areas that required improving in regard to medication records, the guidance available for staff and the quality of medication audits.
● PRN protocols guide staff on when to offer people as and when required medication. These were not signed, dated or had any evidence that they had been reviewed. It was not possible to tell if these were up to date. They contained minimal information and gave little guidance for staff on when to offer people medication. One person had a medication pen picture which outlined what medication a person as taking. However, this differed from their recent medication administration record.
● Medication stocks that we checked were correct and senior staff who administered people's medication had received training to be able to do so safely.

Staffing and recruitment
● There were enough staff to meet people's support needs safely. Staff told us that there had been a high turnover of staff at the home and the service used agency staff to ensure that enough staff members were present. Staff told us that this had recently improved.
● The provider had a centralised system across their services to ensure that new staff were recruited safely in line with best practice.

Preventing and controlling infection
● The home had a housekeeping team, it was clean and appropriate infection control practices were used. The kitchen had been awarded the highest award of five by the local authority for food hygiene.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

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

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

- The human rights act states that people can only be deprived of their liberty when in accordance with a procedure prescribed in law. Some people's care and accommodation were provided in a manner outside of the legal framework. By not following these legal procedures the provider had systematically breached people's human rights and was depriving people of their liberty, when they had no authorisation to do so.
- Senior staff and support staff had no oversight of, and were confused about, who had legally authorised restrictions in place and who did not. Everybody was treated the same and as if they had restrictions of their liberty in place. One staff member told us, "No people come and go [without staff]. There is a locked door and gates, because people escape."
- The home had a very restrictive environment. The provider had taken depriving people of their liberties for granted and had not ensured that people's fundamental rights were acknowledged and protected.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- The provider had not maintained their programme of training and refreshment training for staff. According

to the providers information only about 50% of staff had completed their fire, first aid, health & safety and Mental Capacity Act / DoLS refresher training.
● There was no record of staff receiving training with regard to best practice in how to support a person with a learning disability, autism or a mental health support need. One staff member told us that in their role they, "Felt unqualified and out of my depth."
● Staff feedback about the support they had received was mixed. Most staff told us that the support they received had recently improved. However, staff described a culture where they had felt "burnt out" and that retaining staff at the home had been difficult. We were told that staff had asked for help and support and it had taken a long time to receive this support.

Staff had not received appropriate support and training to enable them to be effective in their role. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Some aspects of the design and adaptation of the environment was not working for people and some people only had access to limited outdoor space. Also, staff described people at the home "clashing" and the environment within the home not always helping them to manage this. For example, there was no TV in one lounge and it was bare. A senior member of staff told us that the TV had previously been removed because people at the home disagreed over what channel to watch.
● There were some quiet lounge areas. However, these were locked, and people did not have access to them without asking staff to open them. Also, there were gates and railings on the steps leading up to staff office space. One senior staff member told us that these were put in because, "People had tried to get access to staff."
● Some people had been supported to decorate and personalise their rooms; they told us that they liked their rooms. However, overall the environment was not homely and was mostly bland, featureless and uninviting. Some areas of the home were stark and had broken furniture and tables and chairs secured to the floor at awkward distances. An assessment of the home environment stated the home had a "low stimulus environment / cream walls." However, senior staff could not tell us who needed an environment like this and people's care files we looked at didn't show this was needed.

The provider had not ensured that the home's environment met people's needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care
● Each person had a health action plan. However, these were not always up to date or contained appropriate information. For example, one person's health action plan was not up to date with their diagnosed health conditions. There were no records in their care file with regard to recent GP visits to demonstrate how staff had supported the person with their health conditions. Staff went to the person's GP during our inspection to obtain information that should have been held in the person's health action plan.

People's care records did not demonstrate that people's support had met their health needs. This was a breach of Regulation 17 (Good governance) 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 had assessments in place that outlined their choices and opinions. We saw that these had periodically been reviewed to ensure they were up to date.

Supporting people to eat and drink enough to maintain a balanced diet

● There was a menu in place; however, the chef told us that they are flexible and will adapt as much as possible to people's requests. The chef was knowledgeable about people's dietary needs and preferences.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.
At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant that people were 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 caring in their interactions with people and it was evident that staff endeavoured to have positive relationships with people. Staff had described some difficult times supporting some people at the home. However, staff spoke about people with respect and a fondness when describing these difficult times.

● One person's family member told us, "The staff are nice. [Staff name] is lovely to him and so kind." They also told us that they felt welcome when visiting.
● Whilst staff as individuals had a caring approach towards people; the provider had not developed, promoted or ensured that there was a caring culture at the home that respected and enabled people.

Supporting people to express their views and be involved in making decisions about their care
●The PBS principle of listening to a person by their communication and their actions had not been consistently applied. The culture at the home had not promoted staff being curious and exploring with them, what views or decisions people were trying to communicate.
● There was limited information on what contribution people had made to their care plans. What had worked or not worked and what changes staff had made as a result of people's communication and decisions.

Respecting and promoting people's privacy, dignity and independence
● There were limited opportunities for people to develop skills and increase their independence. The design and environment of the home did not support this and promoted people's reliance on staff members.
● People' support plans were not focused on enabling them to increase the control they had over their life, learn new skills and promote their independence.
● People's private and confidential information was kept secure.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

● Each person had a positive behaviour support plan (PBS). The provider states that PBS is an understanding of a person's communication and behaviour which can then be used to develop their support to improve their quality of life. There is evidence that this may have been responsive to people's needs in the past and people had been supported to set goals and achieve these goals; however, we found that people's support and staff approach had changed from what had been planned.

● For example, one person's support plan stated, "If I can't do something explain to me why and follow up with something I can do." We saw a number of incident reports that showed that staff were not listening to the person or following this approach. Instead they had described the person's actions as; "demanding", "wanting authority" and "not understanding simple instructions". This did not support the person to have maximum choice and control.

● Also, for another person there was a system that rewarded them for completing daily tasks for themselves. When a task was completed they received a token which could be used towards "big days out". This was documented in the person's care plan and communicated to their social worker. However, staff had evolved this system to include the person losing tokens for having an "incident" and when the person did not keep up their "positive behaviour"; resulting in the persons day out being out back. This was not following the providers PBS model, gave staff a lot of power over the person's life with minimal guidance, was controlling and punitive and was wide open to inconsistencies from staff members.

● One staff member described how different members of staff supporting people in different ways was at times a cause of upset.

The provider had not ensured that people's support had met their needs, preferences and was in line with their agreed support plans. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Often these plans had not been completed following the provider's guidelines. For example, the date when people's plans were completed, who supported people to complete and understand their plans and when they were due to be reviewed was not recorded.

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

● Each person took part in activities that were important to them. People's support plans contained information on what activities people had and had not enjoyed along with a planner of when people had

chosen to do certain activities.
● People had attended social events and had meals out. People walked to the local town centre which was close and contained shops, places to eat, bowling and a theatre. On occasions people had been supported to have trips out, short breaks and holidays. One staff member told us that they really enjoyed supporting people to go on a holiday and this had been a highlight of their role.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff adapted their communication style to ensure that the were able to communicate effectively with people. We saw that people's support plans contained information on a person's communication style and guidance for staff on how to effectively communicate with people.

Improving care quality in response to complaints or concerns
● The provider had a system for recording complaints, concerns and compliments received by the service. We looked at this record and saw that complaints had been investigated and responded to. One person's family member told us that they felt confident in the staff and would be "happy to speak up" if they had any concerns.

End of life care and support
● Nobody was receiving end of life care. The provider had consulted with people and their families to find out if they had any wishes if this arose. Some people had chosen to make their wishes know to staff which had been recorded.

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.

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

- People's fundamental rights had at times been taken for granted by the provider. The provider had not ensured that the planning and delivery of people's support was in line with the values of Registering the Right Support and other best practice guidance. The provider had not included people in a meaningful way and promoted their choice, control and independence. People's right to live as ordinary a life as any other citizen had not been promoted.
- The previous managers of the service had left. The home had a new deputy manager and a new manager who was in their induction period and was not registered with the Care Quality Commission. The provider told us that they were supporting the service during this period using managers from other areas of the organisation.
- The provider had not ensured that the home had a positive culture. Staff including senior staff told us that there had been a very negative culture at the home. One senior staff member told us, "Staff didn't feel like they could talk openly. They didn't feel that anything would happen if they did." Another senior staff member said, "Some staff did not get on with managers." A third told us, "Staff did not get any praise or encouragement." A fourth told us that the service was "rudderless".
- Staff described a lot of unsettling changes at the home. They told us that they enjoyed their roles. Staff had tried to continue with a caring approach in difficult circumstances without appropriate guidance and support from the provider.
- Staff told us that there had been recent improvements at the home. Some staff told us that communication could still be improved. For example, some staff told us that there had not been a team meeting to communicate with and update staff since the new managers had arrived.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A representative from the provider spoke about the previous management and how it was now apparent that the home had not been well led. However, the provider had not changed, and it is also the providers responsibility along with the registered manager to ensure the quality and safety of the service provided for people.
- There was a lack of oversight of the service; including a lack of oversight of recent events. The oversight of risk was inconsistent, fragmented and ineffective. Risk assessments and the provider's response to significant and serious incidents was ineffective.
- The oversight of the legal framework for the safeguarding of people's right to liberty was absent.

● Staff behaviours, systems and cultures had developed and operated outside of people's authorised care and support plans.
● Staff had not been supported to be effective in their roles.
● Quality assurance systems had not been effective and had not enabled the provider to be assured that the service was safe and of high quality.

The provider had not assessed and improved the quality and safety of the service provided for people. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 and the provider are legally obligated to inform the CQC of certain events that affect or risk people's health and wellbeing; this is by way of a statutory notification. The provider had failed to ensure that the CQC were informed of all notifiable events.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had not engaged effectively with people using the service or staff members. We saw that people's communication was not always listened to or considered and staff described a culture that did not engage with them. One staff member told us, "Up to six times [I] fed back ideas and didn't feel listened to."

Continuous learning and improving care; working in partnership with others
● The culture at the home was not one of learning and improving people's care and support.
● The provider had not always ensured that they communicated with and worked in partnership with outside professionals. For example, one person's social worker told us that they had not been informed of the frequency and seriousness of incidents in one person's support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people's support had met their needs, preferences and was in line with their agreed support plans. The provider had also not ensured that the home's environment met people's needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was depriving people of their liberty when they had no authorisation to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The assessing, monitoring and management of risk in people's support was inadequate.

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 The provider had not ensured as much as possible that people were safeguarded from the risk of abuse.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff had not received appropriate support and training to enable them to be effective in their role.

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 17 HSCA RA Regulations 2014 Good governance The provider had not assessed and improved the quality and safety of the service provided for people. Records of people's care and support did not always demonstrate that effective support had been provided.

The enforcement action we took:

We issued the provider with a warning notice.