Oakfield Psychological Services Limited

Wellfield

Inspection report

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30 July 2020
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10 August 2020

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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

The published date on this report is the date that the report was republished due to changes that needed to be made. There are no changes to the narrative of the report which still reflects CQCs findings at the time of inspection.

About the service
Wellfield is a residential care home providing accommodation, care and support for up to two people. It is also registered for the regulated activity of treatment, disease, disorder and injury and can offer a therapeutic service to the young people living at Wellfield. At the time of our inspection there were two people living at Wellfield, both under the ages of 18.

People's experience of using this service and what we found
People did not always receive safe care. Systems were in place but not operated effectively to keep people safe from harm or abuse. Before and during this inspection we identified numerous safeguarding concerns, which had gone unreported by the service. Risks to people's care were not always managed safely and staff were not appropriately trained to deal with the complex behaviours displayed on occasions by the young people living at Wellfield.

We found widespread shortfalls in the way the service was managed. Quality assurance processes were not effective in identifying and addressing all the issues found at this inspection and in driving improvements.

There was a risk of people receiving inappropriate care. A registered manager of the service had de-registered from the post in April 2020. A new manager was in post and received registered manager status on the day of our inspection. The nominated individual did not always have good oversight of the day to day running of the service.

The service didn't apply the full range of 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 as the young people had a lack of choice and control.

Staff did not support people in the least restrictive way possible and in their best interests. For example, an inappropriate method of restraint had been used on one young person with no legal authority in place. Policies and systems in the service indicated the need to give people maximum choice and control but this was not reflected in staff practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

This was the first inspection of this service since being registered with the Care Quality Commission in January 2020.

Why we inspected
Before our inspection we received information of concern in relation to the lack of appropriate training staff received in the use of restraint. We were told of the risks posed to the young people living at Wellfield and how the culture of the home impacted on their care. As a result, we made further enquiries with other stakeholders in the service, including two out-of-area local authorities commissioning care placements. Initially we planned to do a focused inspection to review the key questions of safe, effective and well-led but collected enough information and evidence during and after the inspection to produce a comprehensive inspection.

We found evidence during this inspection that people could be at risk of harm. We reported these concerns to the provider who took immediate action to make improvements and promote people's safety. We informed the host authority, two authorities commissioning care, clinical commissioning groups and safeguarding teams of our concerns. We found the actions taken by the provider had been effective in mitigating urgent risks, however other significant improvements were required.

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 monitor the service 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 of the Health and Social Care Act Regulations 2014 in relation to safe care and treatment, dignity and respect, safeguarding service users from abuse and improper treatment, premises and equipment, good governance and staffing. We also identified a breach of Regulation 18, notification of other incidents, of the Care Quality Commission Regulations 2009. A fixed penalty notice was served on the provider in relation to this breach and was paid.

Please see the action we have told the provider to take at the end of this report.

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**

Wellfield

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
This inspection was carried out by three inspectors. One adult social care inspector and a children's services inspector attended the home and spent time on site. Another adult social care inspector spoke to staff over the telephone to gather their views on the service.

Service and service type
Wellfield 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 manager received registration with the Care Quality Commission on the day of our inspection. 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 announced. We gave 24 hours' notice of the inspection. Due to the COVID-19 pandemic we wanted to review documentation remotely and also make arrangements to speak with staff and other stakeholders in the service by telephone after our site visit. This helped minimise the time we spent in face to face contact with the manager, staff and people who used the service and the risk of the spread of infection was minimised.

What we did before the inspection
Before the inspection we reviewed information we had received about the service since registration, including any notifications received by the CQC. A notification is information about important events which

the service is required to tell us about by law. The service had not submitted any notifications since its registration in January 2020. We used recent feedback from other stakeholders, including commissioners of care from two local authorities. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
Inspection activity started on 29 July 2020 and ended on 10 August 2020. We visited the service on 30 July 2020. Between the 31 July and 10 August 2020, we sought further information and documentation from the provider. During our visit, we spent time speaking with the registered manager, other members of the management team, clinical support workers on shift and spoke with people living at Wellfield about their experiences of the care provided.

Whilst on site we looked at care records for people living at the home and looked at incidents that had occurred in the service or community. We looked at training and recruitment records for staff. We also reviewed various policies and procedures and the quality assurance and monitoring systems of the service.

After the inspection
We spoke with seven members of staff over the telephone including clinical support staff, an assistant psychologist and a mental health nurse. We also spoke with a young person who had recently left the service. We contacted two professionals to gather their views on the service.
We reviewed a range of records. We reviewed most of the documentation remotely by asking the registered manager and the clinical governance and audit lead to send us key information before and after our site visit. We continued to seek clarification from the provider to validate evidence found and received evidence regarding immediate action we asked the provider to take. We contacted Ofsted to discuss contact and communication they had had with the service before it was registered with the Care Quality Commission.

Following the receipt of further concerning information around staff practice, we shared our initial findings with the host authority, commissioners of care and social workers.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this service. At this inspection this key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, learning lessons when things go wrong
● Not all risks to young people had been identified. Following an incident or an accident new risks were assessed and mitigated against, but actions taken were not always appropriate. Positive risk taking had not been fully explored. Staff lacked relevant experience to safely manage risks. This put people at risk of harm.

●. The provider had not ensured the use of restraint was always safe, proportionate or appropriate.
● Systems and processes in place to ensure incidents were thoroughly investigated, reviewed and reported by the provider were ineffective. The service did not ensure lessons were learned when things went wrong, and the provider failed to ensure safety concerns were reported to appropriate external bodies.

The registered person(s) failed to provide care and treatment in a safe way as processes in place to assess and appropriately manage risk were not followed. Once risks were identified actions taken to mitigate these were not always appropriate. 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 provider responded immediately after the inspection. They confirmed they were working to put in place appropriate arrangements to manage specific risks to people's care and environment to ensure their safety.

Systems and processes to safeguard people from the risk of abuse
● The provider did not have effective systems in place to protect people from the risk of abuse. Management were not always clear about when to escalate concerns to the local authority and when to submit notifications to the CQC.
● There had been a failure to escalate concerns to the appropriate agencies and to the regulator of care, the Care Quality Commission, as is the law. People living at Wellfield were not always safe. For example, one person received a physical injury from a hospital member of staff whilst receiving treatment. This incident was not investigated or reported, to help safeguard the individual in future.
● Staff we spoke with were able to describe signs of abuse and neglect and had received training in this area. However, this training had not been effective because they had not acted appropriately.
● Staff had failed to raise concerns with the host authority and with the Care Quality Commission about the number and severity of the incidents that had occurred in the service. The risk of abuse had gone unreported until the Commission received information of concern from an anonymous source.

Systems were in place but not operated effectively to keep people safe from abuse or improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Staffing and recruitment
● Recruitment was done safely. The provider completed pre-employment checks before allowing staff to start working.
● We noted there was only one reference on file for two new members of staff. We brought this to the provider's attention. Due to the recent pandemic it had not been possible to contact a second referee, but the provider said this would be addressed.
● There were sufficient numbers of staff to deliver care safely. There were enough staff on duty during our inspection to meet the needs of the two people living at Wellfield.

Preventing and controlling infection
● Care staff had been provided with updated infection control training and had access to the correct Personal Protective Equipment (PPE) to protect them and others from the spread of infection.
● The provider told us of the actions they had taken to ensure infection control was followed by all staff during the Covid-19 pandemic.
● Personal protective equipment such as gloves and aprons were readily available within areas of the home.

Using medicines safely
● Medicines were managed safely. Staff received medicines training and competency assessments before they provided support to people with their medicines.
● Accurate records of the medicines they administered were kept by staff.
●There was appropriate storage of medicines with the necessary temperature checks to ensure medicines were stored within acceptable limits and remained effective.

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.
This was the first inspection of this service. At this inspection this key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
● Staff did not receive appropriate support, training and professional development to enable them to carry out their duties. We identified a risk of staff not having specific relevant expertise to manage the needs of children displaying complex behaviours.
● Staff had not received training in a nationally-recognised restraint programme and were having to restrain people on occasions. The Nominated Individual and a member of the senior management team were enrolled onto a MAPA Instructor five day course scheduled for October 2020. Following completion this training would be cascaded to all staff.
● Staff had received some in-house training in restraint, delivered by the Nominated Individual. When outlining the restraint training programme they had completed five of the six support staff we spoke with used the word 'judo' to describe the training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The lack of appropriately and correctly trained staff placed people at risk of inappropriate restraint and the physical and psychological harm this may cause.

● Moving and handling training was not up to date, but the provider could evidence staff had been booked in for this training. Staff identified as requiring refresher training were supporting competent staff with moving and handling transfers.

Adapting service, design, decoration to meet people's needs
● Prior to this inspection the provider had changed the configuration of the home. Due to one person's distress on occasions the provider had chosen to split the house to make two separate living spaces, one to the ground floor and another on the upper floor. There were no communal areas at the time of this inspection.
● Due to the new layout of the house there were no longer any communal areas in the home. Neither was there anywhere for staff to take breaks. We saw two members of staff using a young person's kitchen facilities to prepare their lunch. Staff spent lunch breaks in people's personal living spaces. The person told us this was a regular occurrence.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the premises were not suitable for the purpose for which they were being used.

●The provider had plans in place for an extension in the garden. This would provide training facilities and a separate area for staff.

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). This legal framework did not apply however, in this care setting as the people using the service were under the age of 18, but the Court of Protection framework did.

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.
● One person deemed to have capacity had consented to being kept safe and secure in moments of crisis. A mechanical restraint had been used on this young person on one occasion. We were not assured this was the least restrictive option available to the provider and informed them. They stopped using this equipment immediately
● As one person living at Wellfield was under the age of 16 at the time of this inspection, they were not afforded the protection of the Mental Capacity Act. However, we saw the necessary court of protection order on the young person's support plan.
● The provider did not always follow the best interest's principles appropriately when making decisions on people's behalf about their care and treatment. Relatives or representatives and other healthcare professionals had not always been consulted about people's care and treatment.

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
● We did not see positive behaviour support plans in place. Maladaptive behaviour support plans were formulated after the inspection. These plans outlined the therapeutic strategies in place for people, how these would be delivered and by whom.
● Best practice strategies and guidance were not always adopted or effectively communicated to staff. Staff were not able to consistently apply proactive strategies to prevent behaviour that challenges.
● Comprehensive risk assessments were in place to further support care plans and to inform staff of the risks posed to the young people. These were reviewed and updated to reflect changes in people's presentation. We saw evidence of improvements in general health, such as better hygiene and budgeting.
● The young people living at Wellfield were funded by local authorities that were not local to the home. One person had recently moved into the home.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff were flexible with mealtimes for people and they had access to food and drink outside mealtimes.
● People had access to their own kitchen environments. People were supported to choose their own food and staff were aware of their preferences with regards to meal choices.
● Staff we spoke with were aware of encouraging healthier food choices with the young people they supported and recognised the benefits of this.

Supporting people to live healthier lives, access healthcare services and support
● Following admissions to hospital we saw people received follow-up appointments or contact from relevant healthcare professionals.

● People did have access, when they needed it, to local healthcare services such as their GP and community health services, although due to the Covid-19 pandemic the majority of contact had been via telephone.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well-treated and supported; respecting equality and diversity

- People were not always treated with dignity and respect. One health professional we spoke with told us of their concerns after visiting the home. Staff had used language that was not dignified or respectful when discussing the person.
- A solid door had been installed on the ground floor to separate the home and create two individual living spaces. A caution sign on the door to the ground floor apartment instructed staff the keep the door locked at all times. The use of the door and the sign was not dignified or homely.
- Staff used people's personal facilities as there was no communal space or separate staff room.
- We saw two members of staff using one person's kitchen area to prepare and eat their lunch whilst on a break. This was not dignified for the person; people's privacy was not always respected.

This was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider removed the door and the sign from the service following this inspection and after discussions with the provider.
- People's information was stored securely within the office, and all staff were aware of keeping people's personal information secure.

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

- We saw one person had been involved in making decisions about their care. They had given their consent to be kept safe and secure during periods of distress. This was documented in the care plan.
- The young people living at Wellfield were not known to the advocate. The advocate had last visited the home in 2019, prior to the service registering with the Care Quality Commission. The provider had not contacted or involved an advocate since its registration with the Care Quality Commission in January 2020.

We recommend the service considers making referrals to advocacy services. A child advocate can represent the wishes and feelings of children in looked after care and help ensure discrimination does not occur.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

- People's care plans reflected their current needs. We were not assured that the service always responded appropriately to those needs.
- The service offered therapeutic services to the young people living at Wellfield. Two assistant psychologists were employed to observe and assist in the implementation of day to day therapeutic care.
- The young people living at Wellfield were at times limited as to when they could receive consistent, appropriate and timely therapy support from an assistant psychologist.
- Assistant psychologists were not supernumerary members of staff and were also included on rotas to provide hands-on support for young people living at Wellfield. The role was not always covered on a daily basis and other support staff lacked the relevant knowledge and expertise required to provide meaningful therapeutic support.
- People had been involved in their care planning. One young person had recently moved into Wellfield. Staff had spoken with the young person. A one-page profile and other documents on the person's support plan described the young person well, including their needs, wants and personality traits.

Supporting people to develop and maintain relationships to avoid social isolation

- Clinical support staff engaged with the young people to help them maintain existing relationships and develop new ones.
- Where possible, family links were maintained with the aid of technology, due to the Covid-19 pandemic. People were supported to speak with friends and family members at pre-arranged times if this was outlined in the support plan.
- Staff worked with young people to try and keep them active and develop new interests. Both young people kept pets in the service. Links had been made with nearby stables as people had expressed an interest in working with animals.

Improving care quality in response to complaints or concerns

- The service had a complaints policy that would be followed in the event of a young person making a formal complaint.
- People were given a 'My Rights' leaflet on admission to Wellfield. This explained how to make a complaint to the service and other organisations, including the CQC.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service provided therapeutic support for young people aged between 13-18.
- Information given to people using the service, for example the My Rights leaflet, was in a format that they could understand.
- The service produced one-page profiles of staff in easy read formats and shared these with the young people. This helped people understand the likes and dislikes of staff who were providing the support.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider was not delivering safe care and treatment. A lack of appropriate training in a nationally recognised restraint programme was putting people at risk of unsafe care. There was evidence the management of risk within the service was inadequate.
- Pre-admission assessments had not ensured that people's needs could be safely met before a plan of care commenced. The provider had under-estimated the complexities of the behaviours displayed on occasions by the young people living at Wellfield.
- There were significant shortfalls in the way the service was led. Documents to evidence oversight from head office were not completed. Any audits in place had not identified these errors and therefore the required improvements within the service had not been implemented. The service had been reactive, not proactive, in trying to improve the service.
- The framework for quality assurance was not operating effectively. Whilst policies, procedures and documents within the service reflected good practice these were not always adhered to.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service.

- The provider had a poor understanding of regulatory requirements. Services providing health and social care to people are required to inform the CQC of important events happening in the service. This is so we can check appropriate action has been taken to keep people safe.
- Despite policies and procedures reflecting the need to inform the CQC, the provider had submitted no statutory notifications in relation to any incidents that warranted a referral to safeguarding, or incidents that had resulted in police involvement.
- During a safeguarding meeting held on 28 July 2020, a police officer informed the inspector of 13 occasions that police had either attended the home or responded to staff calls for assistance when in the community, since the service was first registered.

There had been no submission of the relevant statutory notifications by the provider to the CQC, as is the law. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

outcomes for people
● The provider had failed to create an empowering, open and person-centred culture. There was a lack of engagement with external professionals and a lack of reporting incidents through the correct channels.
● The organisation of the staff rotas meant people's needs could not always be met. Good outcomes for people were not always being achieved.

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 manager and nominated individual did not fully understand the duty of candour. This requires the provider to be honest with people, their representatives and other professionals when things had not gone well.
● We saw when incidents happened the provider notified the commissioners of the service, although there were sometimes delays with this process. We did not see people using the service had been consulted or involved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Visits to the service were limited due to Covid-19 but reviews were continuing via telephone. The service needed to involve and work more closely with external health and social care professionals. For example, there had been no contact with the host local authority since the service had become registered in the Manchester area.
● Staff told us they felt supported by management. If they expressed any concerns staff were confident management would listen. Staff had the opportunity to discuss the running of the service at staff meetings.

● Young people were consulted at regular intervals for their opinions on the service. The service engaged with health professionals and staff but had not yet sought formal feedback about the service. The registered manager planned to do this in the future.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Staff had used language that was not dignified or respectful when talking about one young person to a professional. Staff used people's personal facilities as there was no separate area for staff.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Despite policies and procedures reflecting the need to inform the CQC, the provider had submitted no statutory notifications in relation to any incidents that warranted a referral to safeguarding, or incidents that had resulted in police involvement.

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems in place to ensure reported safety concerns were addressed were not followed. The provider failed to provide care and treatment in a safe way as they did not have adequate systems to assess and appropriately manage risk. Once identified the provider failed to mitigate known risks.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There had been a failure to escalate concerns to relevant bodies to help keep people safe. Systems were in place but were not operated effectively to keep people safe from abuse or improper treatment.

The enforcement action we took:

Notice of Proposal

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 provider had changed the configuration of the home. There were no communal areas of the home and no separate areas for staff. Staff used people's facilities and spent lunch breaks in people's personal living spaces.

The enforcement action we took:

Notice of Proposal

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 There were significant shortfalls in the way the service was led and a lack of oversight from head office. Any audits had not identified errors and the required improvements had not been implemented. The service had been reactive, not proactive, in trying to improve the service. The framework for quality assurance was not operating effectively. Whilst policies, procedures and documents within the service reflected good practice these were not always reflected in practice.

The enforcement action we took:

Notice of Proposal

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 There had been delays in staff receiving appropriate training to manage complex behaviours. Staff did not receive appropriate support, training and professional development to enable them to carry out their duties. Staff did not have the relevant expertise to manage the needs of children displaying complex behaviours.

The enforcement action we took:

Notice of Proposal