Ocean Recovery and Wellness Centre Ltd

Ocean Recovery and Wellness Centre

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1715975287	Ocean Recovery and Wellness Centre	Ocean Recovery and Wellness Centre	FY2 9NS

This report describes our judgement of the quality of care provided within this core service by Ocean Recovery and Wellness Centre. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Ocean Recovery and Wellness Centre and these are brought together to inform our overall judgement of Ocean Recovery and Wellness Centre.

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

During our visit to the service we found;

Several area's of serious concern regarding fire safety issues. These issues placed staff and people who used the service at risk which was avoidable. We reported our concerns to the local Fire service

Policies and procedures which were out of date

A lack of evidence to demonstrate effective monitoring of the service provided to drive improvement

Staffing rota's which did not reflect actual staffing levels

Lack of supervision for staff

Staff records which were missing or incomplete

A lack of visible leadership

However, we also found that;

People who used the service were very positive about the care and treatment they were receiving from staff within the service

The service provided care and treatment which was evidenced based and supported people's recovery

The service provided a range of therapies and facilities to assist people with their recovery

Staff were motivated and committed

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found that:

- There were several concerns regarding fire safety issues.
- There was no documented evidence to demonstrate that staff were undertaking the daily, weekly and monthly checks as stipulated in the fire procedure.
- A gate allowing access to the front of the building via a fire door was bolted. The gate could not be opened as it was rusted, thus preventing a means of escape.
- The exit route from the third floor fire escape led to a flat roof and then down the external metal fire escape. The flat roof had a railing fence around it. The fence was waist height and was not a solid structure. It was therefore possible for someone to slip under the barrier and fall.
- The metal fire escape from the third floor fire escape led to a gate opening inwardly. This was blocked by a large grey industrial waste bin. This would have to be removed by staff so people who used the service could then exit safely to the front of the building.
- The ground floor lounge and dining room which were fire doors were wedged open with wooden wedges.
- There were no notices displayed throughout the building to indicate the routes people who used the service and staff should take in case of a fire.
- In the staff records we looked at, we found the staff induction checklists, which included fire safety had not been completed.
- Staff rota's did not reflect the number of staff we were told were on duty per shift.
- People's risks were assessed however, there were no personal evacuation plans in place for each person in the event of a fire.
- The service had a safeguarding policy in place. However; this policy was not specific to the service and was out of date.
- The service had suitable arrangements in place for the administration, storage and management of medicines.

Are services effective?

We found that;

- Staff files were incomplete or not available for scrutiny. It was not possible to determine that all staff had received relevant checks such as Disclosure and Barring Service (DBS) and references which is a regulatory requirement

Summary of findings

- There was a lack of evidence to demonstrate that all staff had received necessary training such as fire safety training, infection control and health and safety
- There was a lack of evidence to show that staff received regular supervision
- People's needs had been assessed in a timely manner
- The service provided treatment which was evidenced based and promoted the recovery of people using the service
- People were fully involved in their care and treatment plans
- People had access to a range of therapies and interventions to promote their recovery

Are services caring?

We found that;

- The service was caring and people were treated with kindness and respect
- All the feedback we received from people who used the service regarding their care and treatment from staff was positive
- People were encouraged to be involved in their care and treatment
- Carers were involved with the consent of the person

Are services responsive to people's needs?

We found that;

- Access and discharge to the service was managed appropriately with the involvement of the person
- People were offered support from the service post discharge for up to two years
- The service had good facilities and activities to support people in their recovery. Activities were available over seven days a week and were rarely cancelled.
- The facilities provided promoted recovery, comfort, dignity and confidentiality for people and met their needs.
- Food options were good as was the quality of food provided.
- The service did not have an up to date, appropriate complaints policy in place. Information about how to make a complaint was not routinely available for people.

Are services well-led?

We found;

- There was a lack of visible leadership within the service.

Summary of findings

- There was no evidence to demonstrate the service undertook any audits to monitor and assess the service provided other than exit questionnaires for people leaving the service.
- Governance arrangements were not embedded to drive improvement or identify 'gaps' in service provision.
- It was not clear if there was a proactive long term plan in place to ensure that there would be adequate staffing levels in the event of increased bed occupancy.
- Staff duty rota's did not reflect the number of staff on duty.
- We found a number of fire safety issues which had not been identified by the service.
- Staff records were incomplete or missing.
- Staff were committed and motivated in their work.
- The visions and values of the service were clearly set out and understood by staff.

Summary of findings

Information about the service

Ocean Wellness and Recovery Centre provides 24 hour care and treatment for people who are undergoing detoxification from alcohol or substance misuse. The service is based in a central location on the promenade in Blackpool centre. It has 18 beds over three floors. The service accepts referrals from male and females aged 18 or over nationwide. The service accepts referrals for people who are privately funded or NHS funded.

At the time of our inspection, there were five people who were receiving care and treatment at the service.

Our inspection team

Out inspection team was led by a CQC inspection manager and two inspectors.

Why we carried out this inspection

We carried out this inspection in response to anonymous whistleblowing concerns we had received about the service. The concerns we received were in relation to;

- Inadequate fire safety procedures
- Poor staffing levels and
- Medication issues

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Prior to inspecting the service, we reviewed information we held about the service. We carried out a focussed unannounced inspection on the 3rd June 2015.

We spoke with staff and people who used the service. We also reviewed the care records of people using the service and staff files. We looked at information the provider held about the service including policies and procedures.

What people who use the provider's services say

We spoke with two people who used the service. People we spoke with were very positive about the care and treatment they were receiving from staff within the service.

We reviewed five exit questionnaires people had completed prior to them being discharged from the service. The feedback was very positive and people reported the service had fully supported their recovery.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that;

- The service is fully compliant with fire safety requirements
- The service is fully compliant with health and safety requirements
- Staff records are complete and available for scrutiny
- Staff receive regular supervision and this is evidenced
- The complaints policy is up to date
- Information regarding complaints is available for people who use the service
- The safeguarding policy is up to date and relevant to the service
- There is a process in place for the effective monitoring of the service

Ocean Recovery and Wellness Centre Ltd

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Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ocean Recovery and Wellness Centre	Ocean Recovery and Wellness Centre

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

During our visit to the service we identified several concerns regarding fire safety issues.

- There was no documented evidence to demonstrate that staff were undertaking the daily, weekly and monthly checks as stipulated in the fire procedure.
- A gate allowing access to the front of the building via a fire door was bolted. The gate could not be opened as it was rusted, thus preventing a means of escape.
- The exit route from the third floor fire escape led to a flat roof and then down the external metal fire escape. The flat roof had a railing fence around it. The fence was waist height and was not a solid structure. It was therefore possible for someone to slip under the barrier and fall.
- The metal fire escape from the third floor fire escape led to a gate opening inwardly. This was blocked by a large grey industrial waste bin. This would have to be removed by staff so people who used the service could then exit safely to the front of the building.
- The ground floor lounge and dining room which were fire doors were wedged open with wooden wedges.
- There were no notices displayed throughout the building to indicate the routes people who used the service and staff should take in case of a fire.
- In the staff records we looked at, we found the staff induction checklists, which included fire safety had not been completed.
- Staff rota's did not reflect the number of staff we were told were on duty per shift.
- People's risks were assessed however, there were no personal evacuation plans in place for each person in the event of a fire.
- The service had a safeguarding policy in place. However; this policy was not specific to the service and was out of date.
- The service had suitable arrangements in place for the administration, storage and management of medicines.

Our findings

We looked around the interior and exterior of the building to confirm what the fire escape routes were in case of a fire on the premises. Staff had advised us there were three external sources of escape. Two were located on the ground floor with one at the front and one at the rear entrance of the building. The third escape route was via an external fire escape on the third floor.

We exited the building via the ground floor rear exit. This was open at the time of the visit. This allowed people who used the service to have access to the garden area for fresh air, access other ground floor facilities or to the smoking shelter. The rear gate which was an escape route to the back of the premises could be opened. However, this was difficult to open as the bolt was rusted. The other gate allowing access to the front of the building via the right side passage was bolted. The gate could not be opened as it was rusted, thus preventing a means of escape.

We went to the third floor to use the fire exit. This could be easily opened via the locking mechanism which could not be locked. This led to a flat roof and then down the external metal fire escape. The flat roof had a railing fence around it. The fence was waist height and was not a solid structure. It was therefore possible for someone to slip under the barrier and fall. The fire escape led to the left side front of the building at ground floor level. The exit route was through a gate opening inwardly into the fire escape space. However this was blocked by a large grey industrial waste bin. This would have to be removed by staff so people who used the service could then exit safely to the front of the building.

We saw there was another door to the left side of the building which had fire extinguisher and a fire alarm at the side of the door. Staff confirmed this was not a fire door and was not used as a route of escape as it did not allow egress to the front or rear of the building. This door was locked by a key which was kept in the main office. On the same corridor area between bedrooms and the ground floor meeting room there was a door which was not a standard fire door. Due to this door being midway between the bedrooms and rear meeting room through which people would exit the building in the event of a fire, it did

not provide a means of preventing fire spreading. We asked Blackpool Fire and Rescue service to look at the arrangements for fire prevention on the ground floor area of the building. We also found:

- The ground floor lounge and dining room which were fire doors were wedged open with wooden wedges. These doors were fitted with self closure devices. Wedging the door open prevented them closing so they would be ineffective in the case of a fire.
- There were no 'running man' illuminated signs or notices displayed throughout the building to indicate the routes people who used the service and staff should take in case of fire.

We looked at the Ocean Recovery and Wellness Centre emergency evacuation procedure. This identified the designated role of the fire manager for the evacuation of the building. We were told that the most senior member of staff on duty would act as the fire manager. In the staff records we looked at, we found the staff induction checklists, which included fire safety had not been completed. It was therefore not possible to confirm from the records whether staff had received a fire induction. There was also no evidence in the staff files we looked at to demonstrate that staff had received fire safety training.

The procedure for fire safety documented that staff should carry out daily checks of the building which included staff walking around the building to check fire escape routes were clear, fire door were not wedged open and fire safety signs and routes were legible.

Other fire checks of the premises and safety measures identified in the fire procedure included:

- Weekly testing of fire alarms points at different areas of the building. Fire alarms were numbered had to record what fire alarm had been tested by activating it.
- Fire doors to be checked for their working order.
- All fire doors should be closed at all times.
- Check fire door intumescent strips and smoke seals were in good working order.
- Fire door signs were legible.

Monthly tests included:

- Testing the emergency lighting.
- Visual checks of fire extinguishers for good working order.

Annual tests included:

- Annual maintenance of portable fire extinguishers

There was no documented evidence to demonstrate that staff were undertaking the daily, weekly and monthly checks as stipulated in the fire procedure. Staff confirmed these checks were not completed. For example the fire log book stipulated weekly visual checks of fire fighting equipment were to be completed but fire extinguishers were recorded as checked in March 2015. However; we found there was another record in use which recorded fire checks of the fire extinguishers checked from 20th May to 2nd June 2015, but there were no records of monitoring in between these dates.

The weekly manual fire test records were only completed for one test on the 2nd June 2015. No other records were provided to evidence the weekly tests had been completed. One fire drill had taken place on 28th May 2015, which was within the six month period stipulated in the provider fire policy.

Emergency lighting was to be tested monthly as per the provider policy and only one record of this was completed for the 20th May 2015.

We saw a completed training record which named ten staff who had completed fire training, but this was not dated as to when the training had been delivered. We asked the two staff on duty if they had completed the relevant fire training as recorded. Both said they had only had fire training in recent weeks within their individual supervision and were not aware of a half hour training session being delivered to ten staff and could not explain why their names were on the record.

The fire risk assessment for the provider dated 6th December 2013 identified there must be a fire safety coordinator who was responsible for the fire safety protective and preventative measures within the building. However staff were unaware of who this was.

The building was clean, tidy and in good decorative order. Staff told us they reported any maintenance issues to the provider and that any issues were dealt with in a timely manner. There were a number of risk assessments in place, one of which was the risk of cross infection identified as high. The existing controls in place were identified as following correct hand washing techniques, storage of waste, following the correct procedure for cleaning bodily fluids and the use of personal protective clothing. Additional controls were spot checks on staff to ensure they

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

were following the correct procedures, designated areas for clinical waste bins and ensuring staff were aware of the infection control policy. The risk assessment was completed in October 2014. Staff could not find an infection control policy to show us the procedures they had to follow to keep people that used the service safe. We were shown a number of Health and Safety Executive (HSE) guidance leaflets for the prevention and control of infection control, for staff to refer to.

There was no risk assessment in place for staff to guide people that use the service on safe use and access to the third floor roof. The roof had a fence around it but this was not a solid structure and was waist height. It was therefore possible for someone to slip or fall under the fence. We noted there were chairs located on the flat roof of the building and staff told us people that used the service could sit out in this area. This could potentially block the fire escape route to the third floor fire escape. There was no guidance for staff on the potential risks to people that used services using this area or escape route.

The service had suitable arrangements in place for the administration, storage and management of medicines.

At the time of our visit, there were two staff on duty. The service employed several therapists and two doctors on a sessional basis. In addition, the service had a housekeeper, cleaner and a chef. Staff told us there were currently five staff employed by the service as care staff.

We looked at the staffing rota's for the previous month and projected month. Staff told us that on a night, there were two staff on duty one of which was a 'sleeping' member of staff. During the day, we were told there were two staff on duty. The duty rota's we looked at did not reflect these figures. For the previous month, there was only one member of staff recorded on the rota for night duty. During the day, there were several days where the rota recorded only one member of staff on duty. We were concerned about the number of substantive staff employed by the service and how the service would be staffed if there was an increase in bed usage. Staff told us they would rely on agency staff.

The care records that we reviewed all contained risk assessments. These covered relevant areas. Risk management plans were detailed within the consultant psychiatrists assessment. However, although people's mobility needs were assessed, we found there were no personal evacuation plans in place for each person in the event of a fire.

In one record we saw a contradiction between the assessment and associated management plan. The person was identified as being an absconsion risk on the assessment. However the management plan stated that the person was not an absconsion risk.

The service had not made any safeguarding referrals since registration. The service had a safeguarding policy in place. However; this policy was not specific to the service. The policy was a local National Health Service trust policy which was due for renewal in 2014 and was not applicable to the service.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We found that;

- Staff files were incomplete or not available for scrutiny. It was not possible to determine that all staff had received relevant checks such as Disclosure and Barring Service (DBS) and references which is a regulatory requirement
- There was a lack of evidence to demonstrate that all staff had received necessary training such as fire safety training, infection control and health and safety
- There was a lack of evidence to show that staff received regular supervision
- People's needs had been assessed in a timely manner
- The service provided treatment which was evidenced based and promoted the recovery of people using the service
- People were fully involved in their care and treatment plans
- People had access to a range of therapies and interventions to promote their recovery

Our findings

The care records that we reviewed showed that people's needs had been assessed in a timely manner. People we spoke to confirmed they had been assessed within 24 hours of their arrival by a doctor who completed a physical examination. However, there was evidence which showed that on-going monitoring of people's physical health needs' was not always followed up.completed. The service did not undertake blood tests however, staff told us that they would request blood test results from the persons' GP if they had recently had one completed by them. They also stated they would refer people to their own GP if they felt they required specific blood tests. However, in one person's care record we reviewed, the person had been identified as not having had hepatitis A, B or C tests or a Liver Function Test (LFT). There was no evidence to show that this had been followed up by the service.

Care plans were in place. However, they were not all comprehensive or completed. For instance we viewed one care plan that only contained two stated objectives. Sections on how these objectives would be achieved, how the patient would be supported and how progress would be reviewed were blank.

The service provided treatment which was evidenced based and promoted the recovery of people using the service. This included the '12 step approach' to detoxification and recovery. People were fully involved in their care and treatment plans.

The service had five permanent care staff employed in addition to a chef, housekeeper and cleaner. There were staff records for only five of the staff. Staff files were incomplete or not available for scrutiny. It was not possible to determine from the staff files that all staff had received relevant checks such as Disclosure and Barring Service (DBS) and references which is a regulatory requirement. We saw evidence that some staff had received training relevant to their role. However, there was a lack of evidence in the staff records we looked at to demonstrate that all staff had received necessary training such as fire safety training, infection control and health and safety for example. Staff had received an annual appraisal. However; there was a lack of evidence to demonstrate that staff received regular supervision. Staff we spoke with confirmed they did not.

Staff were also supported by a range of therapists who provided therapeutic sessions for people on a daily basis.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We found that;

- The service was caring and people were treated with kindness and respect.
- All the feedback we received from people who used the service regarding their care and treatment from staff was positive.
- People were encouraged to be involved in their care and treatment.
- Carers were involved with the consent of the person.

Our findings

We spoke with two people who used the service during our inspection.

People were very positive about the service. One person stated that they "did not want to leave."

Staff treated people with kindness and empathy. One person told us they had been worried about coming to the service but that staff had put them at ease and given them confidence about their future.

One person had reported on an exit questionnaire, " All staff are fabulous in giving me the tools to prepare for a fresh future." Another person commented, "It was the best possible treatment. 10 out of 10 (apart from the staffing)."

Staff engaged with people in a respectful manner.

Both people we spoke with told us they had been given an induction and orientation by staff as part of their admission process. People told us that they were introduced to staff on arrival and at handover. However, this was not recorded in people's case records.

People told us that they were involved in their care. They told us that care plans were discussed with them and they were asked for their views.

We saw evidence in care records that carers and family members were involved in care planning and decisions about treatment where appropriate.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We found that;

- Access and discharge to the service was managed appropriately with the involvement of the person
- People were offered support from the service post discharge for up to two years
- The service had good facilities and activities to support people in their recovery. Activities were available over seven days a week and were rarely cancelled
- The facilities provided promoted recovery, comfort, dignity and confidentiality for people and met their needs
- Food options were good as was the quality of food provided
- The service did not have an up to date, appropriate complaints policy in place. Information about how to make a complaint was not routinely available for people

Our findings

The service accepted both privately and National Health Service funded people. People were assessed for suitability for the service before being accepted. This included a face to face assessment of their needs with a member of staff from the company. At the time of our visit, there were five people receiving care. This meant that there were 12 vacant beds available and no waiting list. People were admitted to the service from all over the country.

Discharges were planned in advance. People were offered support from the service post discharge for up to two years. The provider had another service based in London and staff told us that people had the option to receive aftercare follow up from this service if it was nearer to where they their resided and this was their preference. This included telephone support in addition to individual and group meetings if required. Staff told us that they would contact the persons' General Practitioner to inform them of the their discharge only with the consent of the patient. This included telephone support in addition to individual and group meetings if required.

The facilities promoted recovery, comfort, dignity and confidentiality. There was a range of rooms available to facilitate activities and therapy sessions including a sauna and steam room.

Patients we spoke to told us that the food provided was "excellent." There was evidence of choice available to patients in the daily menus that we reviewed. Patients told us that they had been asked about allergies and food preferences on admission. This was reflected in the case records we saw.

There was a daily programme of activities in place including over the weekend. Patients that we spoke with felt that the activities available were constructive and aided their recovery. We reviewed daily activity plans which included options such as yoga, reflexology, art classes and walk and talk sessions. These were provided by therapists employed by the service on a sessional basis. Patients confirmed that these activities took place and it was rare for them to be cancelled.

Three of the bedrooms were twin occupancy although these were not in use at the time of our visit. Each bedroom had an en suite facility. Patients were provided with a key so they could lock their bedroom door if they wished to. However, we noted there was no lockable space in the twin occupancy bedrooms for patients to store any personal belongings or valuables.

The service had bedrooms on the ground floor for patients who may have mobility needs although there were steps down to the therapy room. Due to the layout of the building, it would not be suitable for patients who were unable to mobilise unaided.

The service had not received any complaints since registration. The complaints policy we were provided with by staff was a single sided sheet of paper. The policy was out of date and did not include the current regulatory bodies to which patients could complain. It listed a regulatory body which has not been in operation for several years.

There was no other information available for patients regarding how to make a complaint. We were told by staff that each bedroom should have a patients' information pack which included information about how to make a complaint. However; we were told the service did not have any.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We found;

- There was a lack of visible leadership within the service
- There was no evidence to demonstrate the service undertook any audits to monitor and assess the service provided other than exit questionnaires for people leaving the service
- Governance arrangements were not embedded to drive improvement or identify 'gaps' in service provision
- It was not clear if there was a proactive long term plan in place to ensure that there would be adequate staffing levels in the event of increased bed occupancy
- Staff duty rota's did not reflect the number of staff on duty
- We found a number of fire safety issues which had not been identified by the service
- Staff records were incomplete or missing
- Staff were committed and motivated in their work
- The visions and values of the service were clearly set out and understood by staff

Our findings

The visions and values of the service were clearly set out and understood by staff. The service promoted recovery within a supportive, therapeutic environment.

Staff explained the purpose, aims and objectives of the service to people when they were referred to the service.

However, we found that there was a lack of visible leadership within the service. Only one staff meeting had taken place since the service was opened in January 2015. There was no evidence to demonstrate that the service undertook any audits to monitor and assess the service provided other than exit questionnaires for people leaving the service. This meant that governance arrangements were not embedded to drive improvement or identify 'gaps' in service provision.

We found a number of fire safety issues which had not been identified by the service.

Staff records were incomplete or missing. Staff had not received regular supervision.

Staff duty rota's did not reflect the number of staff on duty. It was not clear if there was a proactive long term plan in place to ensure that there would be adequate staffing levels in the event of increased bed occupancy (other than a reliance on agency staff) or how this was being monitored by the service.

However, it was clear through speaking with staff that they were committed and motivated in their work.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered manager did not ensure that all premises and equipment used by the service provider were:** **Properly used.** **This is a breach of regulation 15 (1) (d)** **and** **Properly maintained** **This is a breach of regulation 15 (1) (e)** **This was because;** • There was no documented evidence to demonstrate that staff were undertaking the daily, weekly and monthly checks as stipulated in the fire procedure. • A gate allowing access to the front of the building via a fire door was bolted. The gate could not be opened as it was rusted, thus preventing a means of escape. • The exit route from the third floor fire escape led to a flat roof and then down the external metal fire escape. The flat roof had a railing fence around it. The fence was waist height and was not a solid structure. It was therefore possible for someone to slip under the barrier and fall. • The exit route from the third floor fire escape led to a gate which opened inwardly. This was blocked by a large grey industrial waste bin. This would have to be removed by staff so people who used the service could then exit safely to the front of the building. • The ground floor lounge and dining room which were fire doors were wedged open with wooden wedges. • There were no notices displayed throughout the building to indicate the routes people who used the service and staff should take in case of fire.

This section is primarily information for the provider

Enforcement actions

- In the staff records we looked at, we found the staff induction checklists, which included fire safety had not been completed.
- There were no personal evacuation plans in place for each person in the event of a fire.
- There was no records to show that a fire risk assessment had been carried out since registration with the Care Quality Commission.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager did not ensure there were established systems or processes in place to: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity This is a breach of Regulation 17 (2) (a) and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity This is a breach of Regulation 17 (2) (b) This is because; There were no records to evidence that health and safety risk assessments were in place. The complaints procedure was a one page document which out of date and did not refer to current regulatory bodies. There was no evidence to show that people who used the service had been provided with information on how to make a complaint. There was no records to evidence that any audits had taken place regarding the quality of the service provided. There was no evidence to show that the results of audits or feedback from service users was used to drive improvements

This section is primarily information for the provider

Enforcement actions

There were no records to evidence that staff received regular supervision.

There were no records to evidence that the provider had ensured staff had received a Disclosing and Barring Screening prior to their appointment.

There were no evidence to demonstrate there were established mechanisms in place for staff to share lessons learnt or learning from incidents. Only one staff meeting had taken place since January 2015.

The safeguarding policy was a copy of a local NHS trust policy which was out of date for review and not applicable for the location.