Heathcotes Care Limited

Heathcotes Wendover House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Heathcotes Wendover House is a residential care home providing accommodation and personal care to people with a learning disability. The service can support seven people and at the time of the inspection seven people were being supported.

Heathcotes Wendover House accommodates people in one adapted building. All of the bedrooms have ensuite facilities and people share a bathroom, lounge and kitchen/diner.

The service is also registered for the regulated activity personal care to enable them to support people in a two bedroomed supported living service, next door to the care home. At the time of the inspection the regulated activity personal care was not provided. Therefore, only the regulated activity Accommodation for persons who require nursing or personal care was looked at as part of this inspection.

People's experience of using this service and what we found
People told us they were happy with their care but then also gave us examples where they had not felt safe. Relatives were generally unhappy with the care provided. They indicated the service had a high turnover of staff, some staff were not suitably skilled, trained and sufficient staff were not provided to keep their family member safe and enable regular community activities to take place. Relatives told us communication with them was poor and felt the frequent manager changes had impacted on the care and service provided.

Risks to people were not always identified and mitigated. Safe medicine practices were not promoted, and people were not safeguarded from abuse.

Staff were not suitably recruited, and sufficient staffing levels were not maintained to ensure people were provided with one to one care and had regular access to community activities.

The service was not consistently managed and governance was not effective to ensure safe care was provided. Records were not accurate, always dated, secure and fit for purpose.

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

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

Right support:

• Model of care, setting and insufficient staff did not maximise people's choice, control and independence
Right care:
• Care was not always person-centred, and some staff practice did not promote people's dignity and privacy.

Right culture:
• The lack of consistent management meant the ethos and values of the service were not embedded into staff practice, attitudes and behaviours to promote an inclusive service which empowered lives.

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 8 January 2020).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding incidents and whistleblowing information about staff practice. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathcotes Wendover House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding people, management of risks, medicine practices, recruitment of staff, staffing levels, record management, auditing of the service and failure to make the required notifications to us

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

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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Heathcotes Wendover House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector on site over three days and an Expert by Experience who carried out telephone calls to relatives.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Heathcotes Wendover House 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.

This service is also registered for the regulated activity personal care to enable them to support people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living. At the time of this inspection the regulated activity personal care was not being provided and

therefore not looked at.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced, with notice given by telephone from outside the property on day one and day three of the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was in the process of completing their Provider Information Return at the time of the 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. The completed form was received within the required timeframe, this was after the inspection and was therefore not used to plan the inspection.

During the inspection
We spoke with one person who used the service. We spoke with seven members of staff including the regional manager, registered manager, newly appointed manager, two team leaders, an acting team leader and a support worker. We spoke informally to two other support workers and an agency staff member. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and five medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including health and safety, accident/incident reporting, complaints and policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at records such as training data, staffing levels, quality assurance records and a range of policies and procedures. We reviewed a person's file and spoke with five relatives.

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

- This inspection was triggered by concerns raised during a recent local authority strategy meeting and whistleblowing information about staff practice. Some safeguarding notifications received from the service also related to staff practice or failures to follow policies, procedures or protocols.
- During the inspection we observed an occasion where a person was not supported in line with the guidance outlined in their plan of care. This practice did not safeguard the person and placed them at risk of injury. This was reported to the registered manager to act on.
- Another incident that occurred in May 2021 should have been reported to us and the local authority safeguarding team. This had not been identified as a potential safeguarding and did not safeguard the person.
- A person we spoke with told us they felt safe however, they then raised concerns with us about staff practice which indicated a potential safeguarding and that they were not always safe. The registered manager was made aware of the allegation to follow up on.
- Relatives did not feel their family member was always safe. A relative told us staff did not understand their family members medical condition. As a result, there had been occasions where they were not properly supervised and was not given the treatment prescribed and as outlined on the protocol for the condition. Another relative told us a staff member's religious beliefs influenced the way they supported and responded to their family member. This was fed back to the registered manager to follow up on to safeguard people. CQC made a safeguarding alert in view of this feedback.
- Staff were trained in safeguarding and updates in training was identified and scheduled for staff when required. Staff indicated to us they were aware of their responsibilities to recognise and report safeguarding concerns. However, staff practice did not always safeguard people.

People were not safeguarded from abuse. This is 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.

- The provider had safeguarding and whistle blowing polices in place to safeguard people. This information was available in easy read format and accessible to people and staff.

Using medicines safely

- The provider had a medicine management policy in place and staff involved in medicine administration were trained, assessed and deemed competent to administer medicines. However, safe medicine administration practices were not promoted.
- One person's medicine administration record included a number of handwritten records for their

prescribed medicines. These were not complete, accurately transcribed and legible as they did not always show the details as recorded on the label. For example, the full name of the medicine, the route of administration and the dose was not recorded. These were not routinely signed by a second staff member either in line with the provider's policy and best practice on administration of medicines.

● A person had a protocol for the administration of emergency medicine for a medical condition. One of those medicines was being administered in line with the protocol. This had been signed off by the medical professional involved in the person's care. However, it was not prescribed and recorded on the medicine administration record but taken from the persons regular supply of their medicine. This practice had the potential to put the person at risk.

● Prior to the inspection we were notified of an incident that a person's emergency protocol was not followed. Action was taken to prevent reoccurrence. However, a review of this incident did not identify that one of the "as required" protocol medicines was not prescribed and accurately reflected on the person's medicine administration record.

● During discussion with a staff member they told us for a person going on home leave they removed excess medicine from its original packing and put it in an envelope in the medicine cupboard. This was to enable the family member to take home the required quantity of medicine for home leave in its original packaging. The provider's medicine management policy was contradictory as to how medicines away from the service were to be managed, and the policy and staff practice was not in line with best practice and National Institute for Health and Care Excellence (NICE) guidance on "Administering medicines when a person is away from their usual care setting".

Safe medicine practices were not promoted. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to record medicines received, administered and disposed of. Stock checks of medicines took place and protocols were in place for the use of "As required" medicines. Temperature checks were maintained of the medicine cupboard and the room medicines were stored in.

Assessing risk, safety monitoring and management

● Risk assessments were in place for medical conditions such as epilepsy, although one person's care plan was contradictory as to whether staff were to use emergency medicine or call an ambulance. This was updated during the inspection.

● A person's food and fluid was monitored. Their care plan indicated they were to have a reasonable fluid intake, but no target fluid intake was outlined to indicate what was reasonable for the person. As a result, the person's records showed variance in the amount of fluids taken daily.

● During discussion with staff they indicated they were aware of risks to people. However, some actions by staff such as not working in line with care plans and protocols meant risks were not considered by them or mitigated.

● During the inspection we saw a staff member left the service whilst on duty, without ensuring people were adequately supported and supervised. The risks around this had not been considered to promote people's safety.

Risks to people were identified but not always mitigated. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks to people such as falls, choking, moving and handling, life skills and community access were identified and mitigated. Alongside this the service had a LifeVac available to deal with a choking emergency. Staff were trained in its use and the provider had commenced competency assessments of staff

to ensure they had the knowledge and skills to use the LifeVac to deal with an emergency choking incident.
● People who required it had positive behaviour plans in place. These outlined triggers and strategies for responding to people becoming distressed. Guidance was in place to outline when "as required" sedative medicine was to be administered with the benefits and outcome of that recorded.
● The service had an environmental risk assessment in place and people had Personal Emergency Evacuation Plans (PEEP's) in place.
● Equipment such as the gas, electric and fire equipment were serviced, and fire and legionella risks assessments were carried out.
● Daily, weekly and monthly checks of the fire equipment were carried out and in house health and safety checks took place which included checks of window restrictors, shower chair, vehicle, first aid boxes, people's mattresses and individual pieces of equipment such as a person's wheelchair.
● The home was in a poor state of repair and the garden was overgrown. The provider had a refurbishment plan in place and improvement works were due to start later in October 2021.

Staffing and recruitment
● The provider had a recruitment policy in place which outlined the process for recruiting staff. However, this was not followed. We found references from previous employers were not always obtained, dates of employment on application forms did not match the dates on references provided and where three character references were obtained there was no audit trail or risk assessment for this to show an employment reference was sought but not provided.
● Alongside this, gaps in employment were not explored and an up to date photo of the staff members was not on all of the staff files viewed.

Recruitment procedures were not operated effectively to ensure fit and proper staff were employed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Potential candidates attended for interview. Successful candidates completed a medical questionnaire and disclosure and barring service checks (DBS) were carried out on all new staff before they commenced work at the service.

● Each person in the care home were supported by one to one staffing. The registered manager confirmed seven staff were provided on each daytime shift plus two staff worked across both shifts to accommodate two to one community activities for individuals. Three staff were provided at night.
● The rotas viewed showed the staffing levels deemed as required was not always provided. This meant one to one staffing was not provided for people and extra staff were not regularly provided to enable community activities to take place. The provider reassured us this was a recording issue as opposed to not having sufficient staff on duty and told us they had invoices to evidence that gaps in the rota were covered by agency staff. However, we were not reassured by this as the revised rota provided showed shifts where sufficient suitably skilled staff were not provided. For example, from the 21 Sept 2021 to the 10 October 2021 there was seven out of 19 shifts where there was no staff on a crossover shift and 17 out of 38 shifts were the required staffing levels were not maintained. During these time frames there was three long day shifts (total six shifts) where there was no team leader on shift.
● Shift planners were in use but incomplete and from those we saw occasions where one staff member was allocated to two people for one to one care.
● Relatives were generally concerned about the turnover of staff, use of agency staff and the impact that had on their family member. They told us there was occasions where the required staffing levels were not provided, and the lack of drivers and insufficient staffing impacted on community access for their family

members. A relative commented "On Tuesday when I visited there was only four staff, I have been so concerned I visit once or twice a week at the moment".
● Another relative told us their family member required constant one to one supervision but on occasions when they had visited the staff member providing the one to one supervision was not in the room with them. They confirmed they had addressed it directly with staff and management at the time. The provider confirmed in response to the draft report that the person may request time alone in their bedroom and this is accommodated with a staff member sitting outside their bedroom and observing the person on the video camera provided.
● A relative did not feel that staff had the skills, knowledge and training to support their family member adequately and gave us examples where despite training, staff had not followed protocol in relation to emergency medicine administration.
● Staff gave mixed feedback on the training. They confirmed they had received training but mainly online, during the pandemic except for Non-Abusive Psychological and Physical Interventions (NAPPI) training. A staff member commented "The training is not sufficient to support us to meet the specialist needs of the people we support".

Sufficient numbers of suitably trained staff were not provided. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The training matrix provided showed staff were trained and specialist training had been provided such as epilepsy, autism, mental health awareness, person centred care and NAPPI training. An action plan was in place to address gaps in training and ensure updates in training was identified and scheduled.
● Team leaders had completed management training suitable to their roles. However, records viewed, and some practices indicated this learning was then not embedded into practice. The registered manager was addressing this through further workshops which were taking place and scheduled at the time of the inspection.
● Systems were in place to support staff in their roles and staff felt supported. Supervision of staff was not occurring at the frequency outlined in the providers policy. This had been identified by the provider and was being addressed.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. However, throughout the inspection we observed staff wearing the mask off their nose which is not in line with guidance on using PPE effectively.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. However, on day three of our inspection all of the required screening checks were not carried out on us.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules were in place which showed high touch areas were regularly cleaned.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The service had experienced an outbreak and managed to bring it under control effectively.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. During the inspection we observed family visits taking place which was in line with current guidance.

Learning lessons when things go wrong

● The provider had a system in place for analysing accidents, incidents, safeguarding's and complaints across their services. This enabled them to identify services with high reporting and or recurrent incidences and extra support was provided.

● The registered manager confirmed that de briefing sessions took place after serious incidents. However, there was no such record for a recent incident that would fit into the criteria for a debrief. The registered manager addressed this with staff during the inspection.

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 required improvement. 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

- The service had four registered managers since it was registered in September 2017 and there had been other managers appointed whom did not apply for registration. This had led to inconsistent management of the service. The current registered manager was a compliance manager and spent three to four days working at the service. A new manager had been appointed and they were working alongside the registered manager as part of their induction into the service.
- Our findings from the safe domain showed governance processes were not effective to keep people safe. The provider had systems in place to audit the service. Monthly provider visits took place and the quality team worked closely with the service in addressing issues identified in audits or as result of strategy meetings with the local authority. In-house audits were completed which included infection control, health and safety, care plans and medicine management. A medicine audit was dated as completed on day two of our inspection. It failed to pick up the issues we found with medicine practices. Actions plans were in place to address findings from audits. However, those audits failed to identify the shortfalls we found in relation to a delay in safeguarding referrals been made, recruitment, rotas and medicine practices.
- The providers monthly audits viewed dating back to May 2021 had identified the poor state of repair and update of the property. At the time of the inspection the environment remained in a poor state of repair and timely action was not taken to make the required improvements to ensure people lived in an environment that was fit for purpose.
- The water temperature records from August 2021 were unavailable and therefore we could not be assured that safe water temperatures were maintained. This was immediately addressed during the inspection. However, in house checks had not picked up water temperatures were not monitored and addressed prior to our inspection.
- Records were not suitably maintained and fit for purpose. For example, a number of records were not dated, signed and did not always include the name of the person they related too. Some shift planners viewed were not dated and were regularly not completed to show the staff on duty and which staff member was providing one to one care to people. Other records relating to people's care such as mental capacity assessments and a moving and handling assessment were not on file. These were printed off when requested but were not accessible to staff until picked up as part of our review of people's files.
- Throughout the inspection people's files were stored in a cupboard with a broken lock in a communal area of the home and therefore, not secure.
- The provider did not design the service to promote the right support, right care or right culture for adults with a learning disability to promote their independence, dignity and ensure they were supported in an anti-

discriminatory way. Supervision records viewed indicated that conflict between staff in communal areas of the home was not managed appropriately, professionally or routinely escalated to senior managers. There was also no indication of action or follow up to issues raised which did not mitigate potential risks or provide positive outcomes for people. A supervision record showed a team leader referred to distressed behaviours as a person "kicking off".

● During the inspection we observed a staff member referred to a person as a "Good boy" and two staff members were heard discussing the personal care provided to a person in the communal area of the home. This practice did not promote people's dignity and person-centred care.

● Staff found the constant manager changes unsettling and team leaders felt they were mainly left to manage. A staff member commented "I feel confident but not always supported because management has been inconsistent here. As a result, team leaders have to learn on the job and sometimes they do not always get it right."

● Relatives felt able to raise issues with management and issues were addressed. However, the constant change in management made it difficult for them to feel reassured that the service was safely managed. A relative commented "Each manager makes promises but those are never followed through as the manager is not here long enough."

Systems and processes were not operated effectively to ensure the service was effectively monitored and that records were accurate, suitably maintained and secure. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Systems were in place to get feedback on the care provided. A relative survey was carried out during 2021 with an action plan in place to address feedback. Some actions were still outstanding. Relatives told us communication with them was variable and that staff did not use their initiative when supporting their relative. A relative commented "Communication is terrible and emails do not always get responded to. There is no accountability among staff, and they do not use their initiative to liaise with health professionals".

● The service facilitated a one to one meeting for one person. There was no evidence that other people got the opportunity to raise issues and share their view on the service to benefit them.

● Systems were in place to promote communication within the team. A communication book, daily handover records and shift planners were in use. Staff meetings took place quarterly. However, records showed staff were not completing shift planners or handover records fully to promote effective communication.

● Systems to assess and manage risk were not established. Staff felt communication was good and told us they worked well as a team. However, during the inspection we saw staff failed to communicate effectively with other team members when they left the service without informing other team members and did not consider if an agency worker had the skills and knowledge tp support a person to ensure the person was adequately supported and risks mitigated.

Systems in place to seek feedback and promote effective communication to mitigate risks to people were not fully established and embedded into practice. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had sought feedback from staff and other stakeholders involved with the service. The results of the staff survey were analysed as an organisation and each geographical area had a plan in place to address the findings over the coming year. Other stakeholders contacted such as health professionals did

not respond to the survey.

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

● The provider is required to inform us of incidents without delay. The registered manager was aware of their responsibilities to notify us of incidents. However, a recent notification showed a delay of 17 days in the Commission being informed.

● At the inspection we saw reference to an incident that occurred in May 2021 which should have been notified to us. The registered manager advised they had looked into the incident and took action but failed to notify us or the local authority safeguarding team at the time.

● Following the third day of the inspection we had informed the registered manager of feedback from relatives about staff behaviour and practice which required referral to the local authority safeguarding team. This was not actioned without delay and we made the required safeguarding alert to the local authority team to safeguard people. Alongside this the registered manager needed to be prompted to make a notification in respect of the safeguarding incident which had triggered this inspection.

The Commission was not notified of incidents without delay. This is a breach of regulation 18 Notification of other incidents (Registration Regulations 2009).

● We observed the registered manager had a positive relationship with people and regularly spent time with people to deescalate situations. People told us they could go to the registered manager with their concerns and feedback about the service and staff.

● Staff described the registered manager as approachable, accessible and felt able to go to them with any issues or concerns. A staff member commented "[registered managers name] is approachable and accessible even if they are not always here".

● Relatives were concerned about the frequent changes in managers. Some relatives were complimentary of the regular staff and commented "The team leaders are fantastic".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had a duty of candour policy in place to support staff in meeting the regulation. The policy was not developed in line with the duty of candour regulation and this was addressed in response to our feedback. The policy indicated the person or person acting on their behalf must be informed of the incident and this should be followed up with a written apology.

● The registered manager was aware of the duty of candour regulation and to be open and transparent when things went wrong.

● We requested the duty of candour letter for a notification which indicated the duty of candour was applied. We found this was a response to a complaint from a relative about the incident as opposed to the service informing the person and their family member and offering an apology in line with the duty of candour regulation. This was fed back to the provider and a duty of candour letter template was put in place to ensure future incidents fully comply with the duty of candour regulation.

Working in partnership with others and Continuous learning and improving care

● The service had supported a person to source a community work placement. This was scheduled to commence once risks had been mitigated and support networks set up.

● The service liaised with health professionals such as a Speech and language therapist, GP, specialist nurses and community teams involved with individuals. A recent strategy meeting highlighted a breakdown in communication between the service and health professionals involved in the meeting.

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 Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications were not submitted to the Commission without delay and other incidents were not recognised as safeguarding and not reported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were identified but not always mitigated, and safe medicine practices were not promoted

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not robust to ensure the required pre employment checks were carried out on staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient suitably trained and skilled staff were not provided.

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 Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance was not effective and records were not accurate, suitably maintained and fit for purpose.

The enforcement action we took:

We served a warning notice