The Disabilities Trust

Disabilities Trust - 25 Welby Close

Inspection report

25 Welby Close
Maidenhead
Berkshire
SL6 3PY

Tel: 01628824154
Website: www.thedtgroup.org

Date of inspection visit:
20 August 2019
21 August 2019

Date of publication:
14 November 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Disabilities Trust - 25 Welby Close is a care home without nursing. The service supported three people with learning disabilities or autism. The service is situated in a quiet residential area of Maidenhead, Berkshire. The house has two
floors.

The service was not always developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
There were not always clear safeguarding systems in place to protect people from risk of abuse.
It was evident where a safeguarding incident had occurred, the management team had not always followed their policies and procedures and informed the local authority.

Risks to people were not always managed safely. People's risk assessments were not reviewed on a regular basis to ensure they were kept up to date and reflected any changing needs.
Risk assessments were not person centred. All care files contained risk assessments for people which were all initially scored as medium risk. There was no clear matrix or scoring tool to help staff determine what risk rating the assessment should be scored.

Required staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out. However, the management team could not always evidence they had taken a full employment history of staff. We could not be assured staff were been supported by people who had undergone the appropriate employment checks.

Medicines were not always managed safely by the service. For example, where people were prescribed 'as required' (PRN) medication, the service did not always have protocols or guidance in place to ensure that staff knew when to administer PRN medicine.

We recommended the provider consider current legislation related to the safe management of medicines and update their practice accordingly.

The management team used systems and processes to monitor quality and safety in the service. However, We identified some inconsistencies in record keeping that had not been identified from their quality assurance processes

Services registered with Care Quality Commission (CQC) are required to notify us of significant events, of other incidents that happen in the service, without delay. The management team had not consistently notified CQC of reportable events within a reasonable time frame. Three incidents had been identified as being unreported.

People had an autism profile in their care files that clearly highlighted their social, physical, communication and sensory needs to help guide staff when engaging with people.

People were involved in decisions about the decoration of their rooms. All bedrooms were personalised and set out in the way that people wanted. All people had their own bathroom facilities to use.

All people had communication profiles so that staff could clearly see how a person liked to be supported. People's individual care and support needs had been assessed, with assessments in place for areas such as mental capacity, medication, communication and interaction profile.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 28 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive, effective and well led sections of this full report.

Enforcement
We have identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breach in regulation 12 (Safe care and treatment), regulation 13 (Safeguarding service users from abuse and improper treatment), regulation 16 (Receiving and acting on complaints), regulation 17 (Good governance) and regulation 19(Fit and proper persons employed). We found one breach of the Care Quality Commission (Registration) Regulations 2009. This was a breach regulation 18 (Notification of other incidents).

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Disabilities Trust - 25 Welby Close

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 two inspectors on the first day of inspection and one inspector on the second day of inspection.

Service and service type
The Disabilities Trust, 25 Welby Close is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The 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. However, at the time of inspection we were informed by the management team that the registered manager had left their post and they were in the process of deregistering them.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with the regional manager and team leader. We will refer to them in this report as the management team. We spoke to three people about their experience of the care provided. We also observed staff members interacting with people. We looked at three people's care records and their associated medicine records for those that were administered medication. We looked at records of accidents, incidents, and complaints received by the service. We looked at one recruitment records, staff supervision and appraisal records, staff training matrix and audits completed by the management team.

After the inspection
We requested additional information. This included some of the providers policies and procedures. We received feedback from one relative. We requested feedback from five care staff and three professionals but did not receive a reply.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- There were not always clear safeguarding systems in place to protect people from risk of abuse.
- It was evident where a safeguarding incident had occurred, the management team had not always followed their policies and procedures and informed the local authority. It was not clear in records or care files, following a safeguarding incident, that an investigation had taken place. For example, one person was on one to one support but was left to walk alone from the shop, and a police incident occurred as a result. It was detailed in the person care file that they should not be left alone at any point in the community. We raised this with the management team who promptly ensured all safeguarding concerns were referred to the local authority safeguarding team on the days of inspection.
- We found that allegations of abuse incidents were not always reported in a timely manner to the Care Quality Commission as required under the Regulations and we have reported on this in the well-led domain.

The registered person failed to ensure safeguarding systems and processes were established effectively to prevent service users from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not always managed safely. The assessment of need summary was not reviewed on a regular basis to ensure they were kept up to date and reflected people's changing needs
- Risk assessments were not always accurate and reflective of individual people. All care files contained risk assessments for people and they were all initially scored as 'medium risk'. The service would then write in mitigating information where they were all then reduced to low risk. There was no clear risk matrix or scoring tool to help staff determine what risk rating people's assessment should be scored. When we asked the management team how they scored risk assessments, they told us, "We were told to start them all as medium and then score them as low risk." It was not clear how individual risk had been assessed. The management team failed to ensure people's unique risks had been identified and the appropriate safety measure put into place.
- Records of accidents and incidents were recorded either electronically or paper based. There was no consistency in the way they were recorded. Some accidents and incidents lacked detail and did not evidence that any monitoring took place after people had been involved in a safety incident. For example, one person had two separate incidents where they struck a staff member when travelling in a car, there was no record of this in their care file or updates made to their risk assessments to reflect this risk. Following a multi-disciplinary meeting regarding this event there was a list of six strategies to use moving forward. We found, from looking through risk assessments, none of these strategies had been documented or equipment

purchased that had been agreed as part of the strategies to put in place.
● One person's" Health action plan" stated, "My ideal weight is between 63.6kg and 86kg". However, their weight had been recorded consistently at 109kg for a 12 month period. There was no evidence of how this impacted the person, or what management strategies had been put into place regarding weight management.

The registered person failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's personal emergency evacuation plans (PEEPs) were up to date. Each person had a fire risk assessment that highlighted further safety measures which included the level of assistance needed when leaving the building.
● People had de-escalation and intervention techniques risk assessments in their care files that guided staff on how to deal with situations when the person may become stressed or anxious.

Staffing and recruitment
●People were not protected from the risk of being supported by unsuitable staff as recruitment processes required improvement. Some required staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out.
● However, the management team could not always evidence they had taken a full employment history of staff. Satisfactory evidence of conduct in employment that related to previous work in health and social care was not always obtained. We found that the one person employed since the last inspection did not have a full employment history in their file.
● We raised this with the management team on the day of inspection. They stated that they had recently implemented an employment audit check which had identified these missing areas. However, when looking through the audit, these areas had not been identified.

The registered person failed to ensure recruitment procedures were established and operated effectively to ensure fit and proper persons were employed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On both days of inspection there were sufficient staff to meet people's needs. The management team told us they had a minimum of two staff working the day shift and one staff member for the sleep in nights.
● The management team told us that they used bank staff and occasionally agency staff to cover their current vacancies.

Learning lessons when things go wrong
● The registered provider did not ensure effective systems were in place to investigate and monitor accidents and incidents. Records of accidents and incidents lacked detail and did not evidence that any monitoring took place of people after they had been involved in a safety incident .
● The management team did not have any robust systems in place to make sure that learning took place on a regular basis. There was no evidence of how staff would learn from reviews of incidents or concerns.

The registered person failed to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce and mitigate such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Using medicines safely

● We found that medicines were not always managed safely by the service. Where people were prescribed 'as required' (PRN) medication, the service did not always have protocols or guidance in place to ensure that staff knew when to administer PRN medicine. This meant that people may not always get their medicines when they needed them.

● There were monthly medicine audits undertaken by the management team, which highlighted any issues or concerns in a timely way and had clear actions to address deficiencies and outcomes. However, we found that these audits did not identify that people did not have PRN protocols.

● We found that one person's prescribed medication was left outside of the locked medicine's cabinet, that had been open in May 2017 and not returned to the pharmacy when this was no longer needed by the person. The medicines cabinet was in a locked staff office, however we noticed people walking in and out of the office during the inspection. We asked the management team why this prescribed medication was not in the locked medicine's cabinet, and they told us, "It was too big to put inside."

We recommend the provider consider current legislation related to the safe management of medicines and update their practice accordingly.

● Staff were trained to administer medicines safely and their competency to do so was checked regularly.

● Records demonstrated that people had received their medicines as prescribed, in a way they preferred, in line with their support plans.

● Staff accurately completed Medicines Administration Records (MAR). The MAR charts provided a record of which medicines were prescribed to a person and when they were given.

● We carried out a random stock check of medicines, where the number of all medicines in stock was correct.

Preventing and controlling infection

● We saw that the home was clean and free of malodour throughout the duration of our inspection.

● One person told us, "Yes the house is always spotlessly clean."

● Staff received training in the control of infection.

● We saw people making and eating their own food when they wanted and cleaning the kitchen and dining area.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Peoples goal setting plans had not been updated to reflect people's current individualised needs. For example, one person's plan had not been updated since 2017. A second person's plan had written at the bottom in pen that a review had taken place in 2018, but there were no additional goals added, or a review of current goals documented.
- All people were weighed weekly and had a Malnutrition Universal Screening Tool (MUST) completed. However, no people had been identified of risk of malnutrition, and there was no evidence how this information was been used to monitor or assess risk. When we asked the management team why people were weighed weekly, they told us, "It's company policy."
- People's 'autism profile' records clearly highlighted their social, physical, communication and sensory needs to help guide staff when engaging with people. For example, one person's stated, "[Person] can find it difficult to understand when someone is joking, being sarcastic and will usually take what people say literally".
- All people had behaviour support plans in place. These plans were highly detailed and provided information on reactive strategies to use to minimise and prevent behaviours. For example, there was step by step information that guided care staff on how to deal with behaviours that people may present with which may challenge, such as 'signs and symptoms' to look for. It then explained what action would need to take place if an incident did occur. and then what action to take following any incident that may have occurred.
- The management team told us about one person who previously had a history of physical behaviours prior to moving to the Disabilities Trust. They told us they learnt that they needed to plan for one hour prior to taking the person out into the community to help to reduce the persons stresses and anxiety.
- The provider used a traffic lights index that highlighted important information regarding the support people needed at the red, amber and green stage. For example, a red alert, which was "things you should know about me" documented personal information, medication and their capacity to make decisions. The amber alert, "things that are important to me" documented people's communication and dietary requirements. The green alert was for peoples "likes and dislikes". For example, one person's likes stated "The company of other people, social events and music."

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).

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty
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.

● We found that the management team had not routinely applied for DoLS authorisation once people's original DoLs had expired. For example, one person's DoLS had expired in April 2018 and was not reapplied for until December 2018.
● We found in care files where DoLS had been applied for there was no continued communication with the local authority regarding the progression of the application.
● We observed staff seeking consent from people using straightforward questions and giving them time to respond. Staff supported people to make as many decisions as possible.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink however not everyone's choices were considered, for example, one person's "Nutritional needs support plan" stated, "Give [person] a blank menu and they will fill it in. They like to be involved in making their menu with choices available with pictures to help [person] choose."

There was no evidence that they planned their own menu, the only choices they had were from the rolling four-week menu. One the day of inspection the management team did not have any knowledge that this was a requirement written in the nutritional needs support plan.
● We observed mealtimes as an enjoyable and sociable experience for all people. Whilst people were encouraged to eat together at the large dining table, those who wished to have a quieter experience could eat their meals in their rooms. One person told us, "Good, big portions."
● One person had their own unique drinks timetable. The management team told us this was because the person was having to many fizzy drinks which was affecting their weight and was recommended by the GP. This was agreed with the person, where they have since lost weight.
● One person told us, "We have our own choice, but we eat healthy meals. Occasionally we have junk food, but we eat very well and have a good choice drinks."
● It was observed during the inspection that people were able to make food and drinks for themselves when they wanted and could purchase foods that they liked.

Staff support: induction, training, skills and experience

● All training the provider considered to be mandatory was up to date.
● The management team had a list of training they deemed mandatory for staff members. This included fire safety, Infection control, safeguarding, and mental health awareness.

● The management team stated that staff received supervision four times a year. Evidence was seen in staff files that supervision took place.
● One person told us they felt staff were trained to undertake their roles.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked in partnership with professionals from health and social care to meet people's needs.
● Care files contained a "My health action plan". This was evidence of appointments with health care professionals such as General Practitioners (GPs) and dentists.
● One person told us, "Yes I get to see the GP and people when I need to."
● One relative told us that their family member can see their GP and dentists when they need to.

Adapting service, design, decoration to meet people's needs
● People were involved in decisions about the decoration of their rooms. All bedrooms were personalised and set out in the way that people wanted. All people had their own bathroom facilities to use.
● People had their own belongings and equipment such as televisions and music systems, so they could spend time alone if they wanted to with their chosen activity.
● We saw that the house was decorated with pictures where people had previously been on trips, holidays and activities together.
● All people had pictures of their family members in the lounge areas to give their home a personalised feel.
● There was an accessible, enclosed garden which people appreciated.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- We saw a lot of positive interactions between staff and people throughout the day. For example, staff spoke clearly to people and understood when they were anxious and what they needed to put in to place. Where one person became very anxious around new people, staff members were able to describe techniques to use when speaking to them.
- Staff knew people well and promoted their equality and diversity. Staff had a detailed understanding of people's needs and supported them. It was evident on the both days of inspection that staff knew people well and we observed many positive interactions.

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

- People's views on how the service was run and the support they received was regularly sought.
- People had weekly recorded keyworker meetings that reflected on what they had achieved that week. This provided an opportunity for people to express if they were happy and have a discussion around their needs. We saw evidence where one person had raised a concern that their computer had broken, staff had arranged for this to be fixed two weeks later.
- The provider used technology to enhance the delivery of effective care and support. the management team stated they used technology with people where they all had their own secure devices to enable them to keep in contact with family and use for research around their hobbies on the internet
- Care plans were developed with people, their relatives, where appropriate, relevant health and social care professionals and by the staff team who knew them well. One relative told us, "Both [person] and I attend the meetings at which the care plan is managed and updated."

Respecting and promoting people's privacy, dignity and independence

- Rights to privacy and dignity were supported. It was seen that staff would always ask people if they could come into their room.
- People's personal, confidential information was stored securely, and staff told us they maintained confidentiality if people ever needed to discuss sensitive matters.
- All people's bedrooms were decorated to suit their own personal preference.
- All peoples care files contained a "Do's and dont's" support plan. This highlighted what to do when in the company of a person. For example, one person's "Do's" stated, "Encourage [person] to recognise the positives within a situation, whilst also acknowledging the dangers/risk within his concern." Another person's "Dont's" stated, "Tell [person] what he is worried about will never happen."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
● During the inspection we found that records didn't clearly evidence how complaints were managed. When asking the management team how many complaints they had received in the past year they stated none. However, during our inspection in the incident folder we saw evidence of a complaint made from a relative. However, there was an investigation and outcome to this complaint.
● The management team had no documented evidence of how many complaints they had received since the last inspection in February 2017.
● The management team failed to establish an effective operating system for recording and identifying lessons learnt or identifying key themes to the complaints.

The registered person failed to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● One person we spoke with stated they knew the process of how to complain.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● All people had communication profiles so that staff could clearly see how a person liked to be supported. For example, one section highlighted, "[Person] has very sensitive hearing and can become fixated on certain sounds."
● People's individual care and support needs had been assessed, with assessments in place for areas such as mental capacity, medication, communication and interaction profile. For example, a person had an assessment of their communication needs, this explained how the person expressed themselves and how best to communicate with them.
● People were supported to go out in the community with staff and by themselves. People had a weekly activity planner in place to help support and give them structure, which was colour coded dependant on the activity. For example, in one person's care file they had a certificate from where they had volunteered at the same work place for 5 years.

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.

● All care files contained a "Communication profile" which guided care staff on appropriate techniques to use with people. For example, one person's care records stated, "When [person] asks a question they must be answered with a full sentence using the same words as they did."
● Staff understood the needs of each person. We observed staff communicating with people in their preferred way which allowed the person to remain calm and clearly understand the conversation.
● The management team told us about one person where they had supported them to reduce episodes of shouting outbursts. They told us how what signs and symptoms they would look for when the person was becoming anxious/agitated? and the appropriate steps they put into place to minimise these and to help the person with their anxiety. They stated they would take the person out of the situation and into their bedroom, where they would speak to them calmly until the episode had deescalated.

Supporting people to develop and maintain relationships to avoid social isolation; Support to follow interests and to take part in activities that are socially and culturally relevant to them
● People had access to activities and trips to support them to follow their interests and give them meaningful experiences. For example, we saw a number of pictures in people's care records and in their home where people had been on trips to Germany, Amsterdam and London and activities such as helicopter rides.
● All care files had a "Friends and family contact sheet" with recorded entries to help people keep in touch with relatives and maintain relationships.

End of life care and support
● The management team told us people with end of life care preferences were recorded in their individual care plans, with family involvement when needed. However, we found that some plans were not personalised and only contained minimal information. The management team were unaware of this and stated that they would look to personalise this for people.
● The management team told us staff received online training in end of life care.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● Services registered with Care Quality Commission (CQC) are required to notify us of significant events, of other incidents that happen in the service, without delay. The management team had not consistently notified CQC of reportable events within a reasonable time frame. Three incidents had been identified as being unreported.

The registered person had not notified the commission of significant events, of other incidents that happen in the service, without delay. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It is a condition of the providers registration with the Care Quality Commission (CQC) that the service has a registered manager in place. There was not a registered manager in post at the time of the inspection. They told us that they were in the process of recruiting a new registered manager.

● The management team did not always have effective quality assurance systems in place to ensure and evidence that they had reviewed the service provision to identify any issues.

● We found that peoples care plans had not been updated, and risk assessments had not been reviewed following an incident. This put people at risk of not receiving the appropriate support.

●., The management team could not evidence they used the quality assurance systems to identify any trends and oversee and improve the quality of the service where necessary.

● The management team completed monthly medicines audits, and quarterly human resources, lifestyle, nutrition and participation audits. However, medicines audits did not identify that some people did not have PRN protocols in place.

The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records were easily accessible and care plan documents had been signed by the management team and reviewed.

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

● We saw evidence that when incidents occurred, the management team acted in line with the duty of candour.

● The management team did not have effective operating systems and processes to promote person-centred care. There was some evidence that the service did have a focus on achieving good outcomes for people however this was not supported by robust documentation.

Continuous learning and improving care

● We found that where an accident had occurred there were limited quality assurance or governance systems in place. It was not clear how the management team identified areas for service improvements.

● We did not see any systems in place where the management team had focused on continued service improvements.

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

● The management team told us that in 2018 they undertook a stakeholder questionnaire that was sent to all staff. Following this, all feedback was given to staff and a service action plan put into place which identified areas for improvement.

● The management team told us that an annual questionnaire was sent out to people and relatives. However, we did not see evidence of this, or any learning from feedback that was received. They also stated that a stakeholder questionnaire is given to professionals when they visit the home. However, we only saw evidence of one completed at the time of inspection.

● A relative did confirm that they had been asked their opinion on how the service had been run.

Working in partnership with others

● The management team told us the service had close working relationships with GPs, social workers and the local council. We saw evidence where the service had liaised with professionals during the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not notified the commission of significant events, of other incidents that happen in the service, without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person failed to ensure safeguarding systems and processes were established effectively to prevent service users from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person failed to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person failed to ensure fit and proper persons employed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

Enforcement Action