SHC Rapkyns Group Limited

The Laurels

Inspection report

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22 February 2018

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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

The inspection took place on 21 and 22 February 2018. This inspection was a focused inspection brought forward due to concerns shared with the Commission from the local authority safeguarding team. The concerns were regarding how people were being supported by staff when they presented behaviours which may physically challenge staff and other people living at the home. Our inspection did not examine the specifics of these incidents and allegations. However, we used the information of concern raised by partner agencies to plan areas we would inspect and to judge the safety and quality of the service.

The service has been subject to a period of increased monitoring and support by commissioners. The service has been the subject of multiple safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation.

The Laurels was inspected in May 2017 and rated as 'Inadequate' in the Well-led section of the report due to breaches of Regulations. This included a breach of Regulations relating to ineffective quality assurance systems. At the last inspection in November 2017 the rating improved to Requires Improvement' however the provider remained in breach of Regulations as further work was needed to ensure people received a consistent quality service. The provider wrote to us to tell us the action they were taking.

At this inspection we found the quality of care provided to people had deteriorated as risks to people's health and well-being had not been managed safely. Shortly after the inspection we wrote to the provider. We informed them the Care Quality Commission was significantly concerned about some areas of care and highlighted some new potential risks for people living at the home. The provider had failed to highlight the new concerns prior to this inspection. The provider responded to us and informed us of the action they were taking to improve the quality of care they provided to people living at The Laurels.

At the last inspection we identified incidents of aggression between people had not been reported to external agencies such as the West Sussex Safeguarding Adults team. At this inspection we found people had not been consistently protected from abuse as incidents of physical aggression had not been sufficiently reviewed by the provider and had not been shared with the appropriate partner agencies. We also found staff used inappropriate forms of control and restraint when supporting people who displayed behaviours which may physically challenge others.

At the last inspection we recommended the provider review care documents written on behalf of people. At this inspection care records did not consistently demonstrate people had received the safe care and treatment as referred to in their care plans. This included for people with specific communication and behavioural needs and people who had a percutaneous endoscopic gastrostomy (PEG) feeding tubes.

At the last inspection we found systems to assess and monitor the service were not effective. Shortly after the inspection the provider wrote to us to inform us of the action they were taking. At this inspection we continued to find they were not sufficiently robust as they had not ensured a delivery of consistent, high

quality care across the service or pro-actively identified all the issues we found during the inspection. This included checks made on how medicines were managed and gaps within specific staff training.

At this inspection, there was a registered manager in post who had registered with the Commission in December 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Laurels is a residential care home that also provides nursing care. 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 Laurels accommodates 41 people across four separate units called Birch Lodge, Juniper Lodge, Cherry Lodge and Aspen Lodge. People who live at The Laurels may have a learning disability, autism, physical disabilities and or sensory impairments. Some people had lived at The
Laurels for many years and as such had developed needs associated with advancing age. Each unit had a separate lounge/dining room and there is also access to a communal lounge, a spa pool, a multi-sensory room, gym, computer room and swimming pool. All bedrooms were single and had their own en-suite bathing facilities. At the time of our inspection there were 31 people living at The Laurels.

The Laurels has not been operated and developed in line with the values that underpin the Registering the Right Support and other best practice guidance. The Laurels was designed, built and registered before this guidance was published. However the provider has not developed or adapted The Laurels in response to changes in best practice guidance. Had the provider applied to register The Laurels today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs.

These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen, but this was not always the case for people. The Laurels is a large clinical setting rather than a small-scale homely environment. The Laurels is geographically isolated on a campus in rural Horsham with many people having moved to The Laurels from other local authority areas and therefore not as able to retain ties with their local communities. For some people, there were limited opportunities to have meaningful engagement with the local community amenities. Some people had limited contact with specialist health and social care support in the community due to specialist staff (physiotherapy, dietician) that were employed by the provider. Most people's social engagement and activities took place either at The Laurels or at another service operated by the provider, such as the provider's day centre.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

At this focused inspection we found the service was in breach of four of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, three of which were continued breaches from the previous inspection.

On 26 May 2020 we imposed conditions on the provider's registration telling them how they must act to address serious concerns regarding unsafe care for people with known risks associated with their support needs regarding epilepsy, constipation, behaviours that may challenge, nutrition and hydration, choking and aspiration and monitoring and acting in response to people's deteriorating health. The condition requires the provider to submit a monthly report to the Commission on their actions to improve in these areas.

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.

People did not experience consistently safe care and treatment and were not always protected from harm. Work was needed to ensure systems, processes and practices always safeguarded people from abuse

Some aspects of medicines management were not safe.

There were enough staff on duty and deployed across the home however there were inconsistencies regarding staff skills and competencies to meet people's needs safely.

People were protected from infection due to safe control measures within the home and staff underwent a safe recruitment process.

Is the service well-led?

Inadequate

The service was not Well-led.

The provider did not have effective and robust auditing systems in place to identify and measure the quality of the service people experienced.

The provider had missed opportunities to work with other agencies with the aim of improving service delivery.

People and their relatives were routinely asked their views on the care and support they received informally and formally although improvements were needed to how this information was communicated to people in a way they could easily understand.

The Laurels

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This focussed inspection was brought forward due to concerns raised by external agencies about risk and safety.

This inspection took place on 21 and 22 February 2018. The first day was unannounced and the inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise included learning disabilities and people with complex health needs. The second day was announced and the team included of three inspectors and a specialist advisor. The specialist advisor had specialist experience in Positive Behaviour Support (PBS) and supporting people with a learning disability, autism and/or complex heath needs.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as the inspection took place prior to the publication of the previous inspection report. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of people's complex needs, we were not always able to ask people direct questions. The majority of people who lived at the service could not tell us about their views of the service they received. In order to obtain these 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 spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon. We also spoke with two registered nurses who were employed by the provider, two agency care staff, two permanent care staff, the registered manager, deputy manager and the area managers.

We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed medicines being administered to people. We spoke with one relative and a social worker.

We reviewed a range of records about people's care which included seven care plans. We also looked at three care staff records which included information about their training, support and recruitment record. We read audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports, Medication Administration Records (MAR) and other documents relating the management of the home.

Inadequate

Is the service safe?

Our findings

At the last two inspections in May and November 2017 we identified the service had not consistently protected and safeguarded people from the risk of harm. The provider continued to be in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Prior to this inspection the West Sussex Safeguarding Adults team shared information of concern with the Commission relating to specific allegations of how staff had used forms of inappropriate control and restraint when supporting people in Aspen Lodge, a unit within The Laurels. At this inspection we found staff used inappropriate forms of control and restraint when supporting people who displayed behaviours which may physically challenge others. We identified the provider's systems in place for safeguarding people from harm had deteriorated further and this held significant risks for people living at the home.

At the time of this inspection there were nine people living on Aspen Lodge with complex needs who had a learning disability and some people had a diagnosis of autism. Some people displayed behaviours which physically challenged other people living at the home and staff. Staff had not been trained and supported effectively to gain an understanding of autism and how to reduce a person's anxiety and manage situations of aggression safely, to minimise the risk to other people living at the home and themselves.

We observed staff failed to interact and engage with people and offer the level of stimulation and structure required. They failed to use a Positive Behavioural Support (PBS) approach. PBS is a person centred approach used when supporting people with a learning disability. It involves understanding the reasons for a particular behaviour a person displays in order to plan and implement ways to support the person safely to enhance their quality of life. Staff presented as limited in their understanding of people's complex communication and behavioural needs. As a result, incidents of physical aggression occurred and staff were unable to respond using a consistently safe approach. The staff we spoke with told us about various approaches they used during incidents of aggression. This included how they physically held a person to stop them from moving and how they spoke to a person who was being aggressive to stop them. Methods described were punitive and failed to consider the person as an adult with rights to be protected and treated with respect. For example, one staff member told us how other staff would tell a person if they continued being aggressive they would lock their bedroom door so they could not get into their room when they wanted. They told us they knew this stopped them being physically challenging to others. Another staff member told us they would tell a person they would take their tablet computer away from them if their behaviours continued. These approaches and others referred to were restrictive and not in line with the provider's restraint policy, best practice and safeguarding adults procedures.

At the last inspection we identified incidents of aggression had not been reported to external agencies such as the West Sussex Safeguarding Adults team. At this inspection we read the accident and incident file. We found numerous incidents of physical aggression had been recorded by staff members but had not been reviewed satisfactorily by the provider. There was a lack of detail provided by the staff member at the time to establish if there were any triggers to the behaviours displayed or whether the person had come to any harm. There were no associated records by managers to state the actions they had taken to minimise any further risks to the person. Managers told us they spoke with staff after each incident however there was no

record of this. During the inspection, we spoke with a social worker representing the local authority, who confirmed they had not been informed of the incidents we had read. Considering the guidance the provider had already received from the local authority and the Commission at the last inspection we remained concerned and spoke with the registered manager about this. The incidents were now under the review of the local West Sussex safeguarding adults team. Staff had been trained in safeguarding adults at risk but this had not been implemented in practice when supporting people with behaviours which may challenge others. The failure to recognise significant incidents and escalate them to external health and social care professionals meant there had been missed opportunities to amend and improve staff practice to ensure people were consistently protected from risk of harm.

The above evidence shows that the provider failed to ensure systems and processes protected people from abuse and improper treatment. This was a continued breach of Regulation 13 of the Health and Social Care Act 2014.

At the last inspection we recommended the provider reviewed their care documents to ensure there was sufficient guidance included to promote safe care and treatment. This included for people with specific communication and behavioural needs and people who had a percutaneous endoscopic gastrostomy (PEG) feeding tubes. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and the throat. At this inspection we found inconsistencies within the guidance for staff available and gaps within health monitoring documents to demonstrate safe care and treatment had been provided.

For example, one person had behaviour which could become physically challenging to others. Their care record held three different documents identifying the known triggers for the behaviours the person may exhibit. However, the guidance for staff on what steps and measures to take to minimise the risk for the person and others lacked detail and offered different advice in each. The conflicting information may have influenced the different approaches staff told us they used and what we observed during the inspection.

At the last inspection we identified one person had experienced a wound surrounding their PEG site which was then referred to their GP. At this inspection we checked care records and spoke with registered nurses about people who required PEG management and support they provided. Care records described how PEG tube areas or sites were required to be cleaned daily. The registered nurse we spoke with told us this support was provided. However, the daily records could not confirm the support was provided daily as they referred to general personal care provided not specific to PEG management. Whilst we were not aware of any impact due to the gaps in care records we remained concerned about the potential risk this posed to people who had complex physical and communication needs and were fully reliant on staff to maintain healthy PEG care.

One person had become unwell and experienced some weight loss. They had been seen by a dietician on 30 January 2018. The dietician had recommended the registered nursing staff used a PEG tube for all their fluids to meet their hydration needs. They advised a daily target amount of fluids to be given by nursing staff. We sampled the person's fluid chart which covered 24 hours and had a box at the bottom for the registered nurse to enter the total amount of fluids the person had been given each day. However, the charts we read held gaps. The recommended amount of fluid was not entered on the fluid sheet and the entries made by registered nurses did not indicate the full amount advised by the dietician had been given to the person via their PEG tube. If registered nurses had not read the separate dietician document they would not have known what the recommended amount of fluid was. The potential risk was increased further as the provider routinely used agency registered nurses who may not have known the person had suffered poor health and the associated hydration risks. We have discussed gaps in monitoring documents in the Well-led section of this report.

Prescribed topical creams such as preventative creams for skin integrity issues were applied by care staff during personal care. During our inspection, we looked at the arrangements for managing medicines including obtaining, recording, storing, disposing and administering and found aspects of these systems were not safe. Registered nurses did not record quantities of medicines received into the home and did not check stocks of medicines against people's current list of prescribed medicines. For example, we saw medicines no longer prescribed to people and medicines which had expired past their use date, remained in the home as action to dispose of these appropriately had not taken place. This meant people could have been administered these in error and the home would not know if these medicines went missing. We informed the registered nurse and registered manager who organised the pharmacy to collect any medicines which had expired.

We also found liquid prescribed medicines being used were not always marked with an open date which meant people were at risk of receiving medicines that were not safe or effective to use. For example, we observed a registered nurse administer a liquid medicine to a person. The prescribed medicine was to help reduce the person's anxiety. There was no date on the bottle indicating when the medicine was opened so the nurse would not have known whether the medicine was in date. We checked Medication Administration Records (MARs) and noted there were no specific times marked of when medicines should be administered to people but there was a general period of the day such as morning, lunchtime, teatime and bedtime. Registered nurses told us medicine administration sessions could take a long time which meant there was a risk some people could have time specific medicines too close together. This was potentially unsafe as may have altered the effectiveness of medicines for health conditions such as epilepsy.

We observed one nurse administer a PRN 'when required' medicine to a person to assist in reducing their anxiety. The person displayed behaviours which physically challenged others. The registered nurse recorded the reason and name of the medicine on the back of the person's MAR which informed others the action they had taken. However, they asked the inspector for the time who was unable to provide this to the nurse as they were not wearing a watch. Instead of checking and confirming the correct time they had administered the PRN they wrote down the time they thought it was based on their own estimation therefore a risk the time was not accurate. The lack of care and attention observed held potential risks for the person and their health and well-being as the effectiveness of the prescribed medicine may have been impacted or reduced. This was an unsafe approach and not in line with current best practice or the providers own medicine policies and procedures.

At the last inspection we found three of the four units that formed the service were well maintained, decorated and furnished in a style appropriate for the group of people living in them. Aspen Lodge was not decorated or furnished to the same standard as the other units as furniture was stained and the walls in need of decorating. The provider told us about the action they planned to take including the purchasing of new furniture. At this inspection we found the provider had removed some of the stained furniture from Aspen Lodge and new furniture had been ordered however was yet to arrive and there was a redecoration plan in place. After the inspection health and social care professionals representing West Sussex County Council expressed their concerns regarding poor maintenance within people's bedrooms and communal areas and the need for the home environment to be improved. Shortly, after the inspection West Sussex Fire and Rescue Service carried out a fire safety check. They served an enforcement notice to the provider due to a lack of compliance with fire safety regulations. Areas identified as a fire safety risk included a failure to review the provider's fire risk assessment and failure to provide appropriate procedures in respect of fire safety drills. The provider was given until 28 June 2018 to complete the necessary works.

The above evidence demonstrates that not all was reasonably done to mitigate risks to service users. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection the provider was in breach of Regulations as staff did not always receive appropriate training which enabled them to carry out their role. This included gaps within challenging behaviour and positive behaviour support, autism, emergency epilepsy medicine administration and learning disability training. This meant some staff had not been given the necessary training to meet the needs of the people living at the home safely.

We were presented with two lists of training one was 'mandatory' and one was 'optional' training. Considering people living at The Laurels had a learning disability or autism and other complex health needs, subjects relating to people's diagnosis were not considered mandatory therefore large amounts of staff had not attended them. For example, many people living at the home had epilepsy and some were prescribed emergency epilepsy medicines. However, only nine staff members out of 48 staff had attended epilepsy training and only four staff had attended emergency epilepsy medicines training. Juniper unit had six people with a diagnosis of epilepsy. We spoke with a member of staff on Juniper unit; they had worked for the provider for four years. They said, "I haven't done epilepsy training" and records confirmed this. One person was identified as high risk of choking. Their care plan stated they needed a suction machine in the home and one was to be taken out when supporting them in the community. The guidance also stated that all staff supporting them should have suctioning training but only five staff had attended this. We established staff who were routinely supporting the person outside of the home did not have the training as advised this placed the person at risk of not receiving the correct safe care and treatment in the event of a choking emergency. We fed this back to the management team who were unaware of the essential training staff needed when supporting this person.

The home also used a high proportion of agency care staff. The registered manager had ensured all agency registered nurses had attended core subjects such as PEG management training. However, agency care staff routinely supported people who may physically challenge others on Aspen Lodge unit. For example, on 20 February 2018 four agency staff covered the waking night shift for Aspens Lodge and five out of eight staff in the day time were agency. They had not attended safe de-escalation training. We spoke with two agency care staff who had been working on Aspen Lodge full time between 10 months to a year and neither had attended training to support them in managing behaviours which may physically challenge others. As described earlier in this section, this led to inconsistent and inappropriate actions by staff in responding to people who displayed behaviours which challenged them. The area manager told us, "We need more specialist training". We discussed this with the registered manager who said, "I'm sending them (agency care staff) on training". The lack of training on subjects specific to the needs of people's complex health needs placed people at risk of receiving unsafe care and treatment.

The above evidence showed that staff had not always received appropriate training to enable them to carry out their duties they are employed to perform safely. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there continued to be enough staff working across each of the four units. The provider used a dependency tool to ensure there were enough staff on duty. Some people received one to one support and we observed staff were allocated accordingly. In addition to nursing and care staff the provider employed the support of a physiotherapist and activity co-ordinators who were supporting people at the time of the inspection. The provider also employed a chef, a chef assistant and other domestic staff and maintenance staff including drivers to support the home. A relative we spoke with told us their family member was safe and spoke positively about the care provided, they said, "I feel confident they (staff) understand quite complex situations". They added, "I am happy with [named person's] care".

At the last inspection we identified staff recruitment practices were not consistently thorough as there was a

lack of evidence to support this within all staff members files. However, shortly after the inspection we were supplied with the required documentation. At this inspection we found staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation pin number for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

Environmental risks such as hoist equipment and wheelchairs were managed effectively through prompt and regular servicing. Infection control promoted a safe and clean environment. Equipment was seen to be readily available that promoted effective infection control such as antibacterial hand wash, disposable gloves and clinical waste bins.

Inadequate

Is the service well-led?

Our findings

The Laurels was inspected in May 2017 and rated as 'Inadequate' in the Well-led section of the report due to breaches of Regulations. This included breaches of Regulation relating to ineffective quality assurance systems. At the last inspection in November 2017 the rating improved to Requires Improvement' however the provider remained in breach of Regulations as further work was needed to ensure people received a consistent quality service. The provider wrote to us to tell us the action they were taking. At this inspection we found the quality of care provided to people had deteriorated as risks to people's health and well-being had not been managed safely.

At this inspection systems to assess and monitor the service were in place. However, these were not sufficiently robust as they had not ensured a delivery of consistent, good quality care across the service or pro-actively identified all the issues we found during the inspection. For example, area managers visited the home on a monthly basis. During these visits they spoke with staff and people and sampled records relating to people's care and the management of the home. They would then complete a document accordingly of any areas which required improvement and present this to the manager of the home. This process had failed to highlight issues we found such as the use of restrictive practices by staff on Aspen Lodge, lack of effective recording and reporting of potential safeguarding incidents, gaps in specific training for agency care staff and failure to comply with West Sussex Fire safety legislation. There was also a lack of internal checks in place to ensure that medicines administered to people were managed safely. At the previous inspection a clinical lead who was a registered nurse was undertaking such checks however we were told they were no longer working for the provider.

At the last inspection the provider was in the process of implementing the National Early Warning Score (NEWS). This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. For example, it will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions nurses should take if physiological checks they take are outside of the baseline and a person's health deteriorates further. At this inspection we discussed the system with registered nurses and checked care records. The system continued to be used however, there were gaps within the monitoring documents we read. There were no records of what each person's baseline should be which meant registered nurses did not have a guide to refer to when making health decisions. One registered nurse told us, "I know what is normal for people". Whilst we appreciated the registered nurses we spoke with knew people and their health care needs well we were not able to speak with all registered nurses during the inspection to check this was consistent for all nurses deployed. The risk to people was increased further considering the provider routinely used agency registered nurses throughout the week who may not have known people and their health needs.

Since the inspection the inspectors have attended a safeguarding adults meeting organised by representatives of the local authority West Sussex Safeguarding Adults team. Health and social care professionals shared their concerns with the provider regarding the lack of quality of care being provided to people living in Aspen Lodge, The Laurels. The concerns discussed included reference to a poorly maintained home environment, a lack of understanding demonstrated by staff supporting people with a

learning disability and autism and a culture which failed to offer the stimulation and interaction at the level people living on Aspen Lodge needed. Health and social care professionals also expressed there had been a lack of referrals or advice sought from the local authority West Sussex learning disability team. This included a lack of communication from the provider with psychologists and speech and language therapists. This meant people had not received their input and opportunities had been missed to improve staff practice when supporting people on Aspen Lodge.

This lack of governance over the areas highlighted during and after our inspection potentially placed people living at the home at risk from harm and led to a deterioration of safety in the months preceding our inspection.

The above evidence shows that there were inadequate systems or processes in place that operated effectively to ensure compliance with requirements. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to assess, monitor and mitigate the risks relating to health, safety and welfare of service users. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The current manager was registered with the Commission after the last inspection in December 2017. We shared our concerns with the registered manager, deputy manager and area manager throughout both days of the inspection. Shortly after the inspection we wrote to the provider. We informed them the Care Quality Commission were significantly concerned about some areas of care and safety and highlighted some new potential risks for people living at the home. The provider had failed to highlight the new concerns prior to this inspection. The provider responded to us and informed us of the action they were taking to improve the quality of care they provided. Whilst we recognised the action the provider was taking, we would need to be assured the new systems would be embedded and sustained consistently over a period of time to ensure safe care and treatment was being delivered and having a positive impact on people living in the home.

We checked how the provider gained people and relatives views of the quality of care provided. Surveys were routinely sent out from the providers head office on a monthly basis. The ones we read were all positive. A relative we spoke with complimented the care their family member received and said, "I have liked all the managers, particularly the new chap". People were also invited to attend resident meetings and we read minutes to ones that had taken place. Items such as activities and meal choices were discussed. Minutes to meetings held were in written form only. Whilst some people and their relatives may have been able to read the minutes the majority of people would not have been as they lacked the ability to do so due to the nature of their disabilities. We spoke with the registered manager about making minutes to such meetings in an accessible format such as pictorial for those that required it to ensure people were given appropriate opportunities to be involved with developing the service further.

At the last inspection in November 2017 staff spoke positively about both the registered manager and deputy manager and expressed they had made a positive impact on the support they received. The staff told us they particularly appreciated the monthly supervision sessions the registered manager had introduced when they started. At this inspection staff continued to appreciate the registered manager's support. One staff member said, "I feel supported. The manager has an open door policy for guidance and advice". They added, "There is a nurse in charge on the floor to give us support".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failed to meet Regulation 12 (1) (2) (a) (b) (d) (g)

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failed to meet Regulation 13 (1) (2) (3) (4) (b) (c) (d)

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Failed to meet Regulation 17 (1)(2) (a) (b) (c) (f)

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Failed to meet Regulation 18 (2) (a)

The enforcement action we took:

We imposed conditions on the provider's registration.