Redroof

Redroof House

Inspection report

40 Mill Road
Epsom
Surrey
KT17 4AR

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13 January 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

Redroof House is a domiciliary care agency (DCA) that provides personal care for up to six people who have a learning disability within a supported living scheme. The supported living scheme is located in Epsom and is a short walk from shops and other local facilities. On the day of the inspection five people were being supported. The people have a range of needs and are supported with a full range of aspects of their lives, including maintaining their health and well-being, personal care and support to ensure they have enough to eat and drink.

On the day of inspection we met the registered manager. 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 inspection took place on 13 January 2017 and was announced.

We found three breaches of the regulations and have made three recommendations. You can see what action we told the provider to take at the back of the full version of this report.

We found a lack of managerial oversight of people's overall support. We found examples where concerns with people's support had not been identified by the registered manager. This put people at risk of not receiving the support they needed. The provider had failed to submit information in the form of relevant notifications and a PIR to CQC. This had an impact on us being able to monitor and regulate the service effectively. These were breaches of the regulations.

The requirements of the Mental Capacity Act (MCA) were not being met. The registered manager had not assessed people's capacity and was unclear on who had the legal right to make decision on behalf of people who lacked capacity. Although consent for support was sought staff had a limited understanding of MCA and DoLS. The provider had submitted incorrect DoLS applications.

Although responsibility for DoLS applications falls to the funding authority the registered manager had not followed this up. There was no evidence the funding authority were aware of restrictions in place at Redroof House. On the day of inspection some people were being unlawfully restricted as the right processes had not been followed to allow the front door to be locked. This was a breach of regulation.

Staff felt they had the knowledge and skills to support people with learning disabilities and said they understood how to support people who may become anxious and distressed. Despite this there was no formal training or detailed guidance on how to support people when they became distressed and anxious. We recommended that these areas are reviewed in line with best interest guidance and people's needs.

People said they were treated with dignity and respect and we saw examples of this during the inspection.

Despite this there was a one off incident where a person's privacy was not upheld. Care plans were sometimes written in an undignified manner. We have recommended the provider makes improvements in these areas.

People and relatives said that Redroof House was a safe place to live. Staff understood how to report suspected abuse so that action could be taken if necessary.

Incidents and accidents were reported and the registered manager who reviewed reports to prevent them from re-occurring and implemented actions where necessary to reduce the risk of harm to people. When risks to people had been identified they were appropriately managed. People had risk assessments that staff followed to minimise risk and keep people safety.

People were supported by sufficient numbers of staff who were recruited safely and had the right to work in the UK.

People received medicines in a safe way. Staff had a good understanding of the medicines they were supporting people to take and medicines were stored and disposed of appropriately.

Staff had regular supervisions with their line manager and felt supported in their role. The registered manager used supervisions and team meetings to ask supportive questions of their team to assess their knowledge.

People's nutritional needs were met and people had a varied diet. Staff ensured that people had enough to eat and drink. Staff ensured people were supported to maintain their health and wellbeing and people received support from healthcare professionals when required.

People were cared for by staff who were compassionate and kind. People were not rushed by staff. People were encouraged to maintain relationships with their family and those that mattered to them.

People were encouraged to be involved in how the service was run and people and relatives felt comfortable in raising a concern or making a complaint. Feedback from people and relatives was asked for on an annual basis. This feedback was very good.

The home was led by a registered manager who was a positive role model. An organisational value of providing support that 'fulfilled potential' was understood by the staff team. The registered manager was approachable and visible. Relatives and staff said they would approach her if they had any concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff put practical measures in place to maintain people's safety. Accident and incidents were recorded and staff understood how to report suspected abuse.

People were supported by sufficient numbers of staff who were deployed and recruited safely.

Medicines were administered safely by staff who were trained and competent.

Is the service effective?

Requires Improvement

The home was not always effective.

The requirements of the Mental Capacity Act (MCA) were not met and staff did not have an understanding of DoLS.

Staff felt they had the skills and training to support people's needs and staff felt supported. Training provided did not always reflect people's needs so staff could not support people in line with best practice.

People had food that they liked and their nutritional needs were met.

People had access to health and social care professionals who helped them to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

People said their dignity was respected.

People were cared for by compassionate staff. There was a caring culture amongst all staff members.

People were able to express their views and be involved in their support because staff took time to communicate in a way people

understood.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Support planning involved people and those close to them when required.

People's needs and abilities were assessed and but guidance for staff to follow was not always in line with their needs. Some support plans were written in an undignified manner that did not respond to their needs.

The service had regular tenants meetings and sought feedback from people and relatives through questionnaires.

People knew how to make a complaint and were confident there concerns would be acted on.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service lacked robust quality assurance systems, which put people at risk of not receiving the care they needed.

The registered manager did not keep CQC informed of significant events at the service and failed to submit a PIR.

The service had a positive culture that was person centred, open, inclusive and empowering. The organisational value of providing fulfilling was understood by staff.

The registered manager was visible and communicated well to people and with relatives.

Redroof House

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 inspection took place on 13 January 2017. Due to the size of the service and to make sure people were present during the inspection we notified the service that we were going to carry out an inspection. Before the inspection commenced we asked for permission from people who lived there to come into their home. The inspection team consisted of one inspector who had experience working with people with a learning disability.

Before the inspection, we checked the information that we held about the home and provider. This included statutory notifications sent to us about incidents and events that had occurred at the home. A notification is information about important events which the provider is required to tell us about by law. We also reviewed any complaints, whistleblowing and safeguarding information from relatives and staff. We used all of this information to decide which areas to focus on and to inform the inspection. We did not receive a PIR from the provider before the inspection. When we asked the registered manager he was unsure why this had not happened.

During the inspection we spoke with two people, two relatives, two care staff, the registered manager and the business partner. We observed care and support being provided in the lounge and dining areas. We also observed people receiving their medicines and spent time observing the lunchtime experience people had.

We reviewed a range of records about people's care and how the home was managed. These included three people's care records, medicine administration record (MAR) sheets and other records relating to the management of the home. These included staff training, three employment records, quality assurance audits, accident and incident reports and any action plans.

After the inspection we requested more information from the provider, which was sent to us.

Good

Is the service safe?

Our findings

People said they were safe at Redroof House. One person said, "They make sure you are safe." A relative said, "X is safe. I think X is being well looked after." A compliment from another relative read, 'You did everything to make X comfortable and safe.'

People were supported by staff who were able to describe different types of abuse and knew how to report suspected abuse. All staff had received safeguarding training and had good working knowledge of safeguarding procedures. One member of staff said, "Care needs and the safety of the person are the most important. There should not be any harm or abuse. We would report that." The registered manager had raised concerns with the local authority when appropriate and took action to make sure people were safe.

Staff had identified a variety of risks to people that included access to the community, choking, use of the kitchen and behaviours that may challenge. People were supported by staff who understood how to reduce the risk of harm whilst not restricting freedom. People who could show levels of agitation that could cause harm had risks assessed and measures put in place to help keep them safe. This included one person having a plastic plate and cup at mealtimes to reduce the risk of injury. Some people were at risk of choking whilst eating or drinking, they were referred to the speech and language team for guidance on how to keep them safe whilst eating. We saw this guidance was followed by staff. Some people had allergies which were clearly documented to make sure all staff and medical professionals were aware and had the information to support them safely.

During the inspection we observed times when staff prompted and encouraged people with their health and safety. We heard staff saying, "Hold onto the banister and come down slowly," as they supported a person down the stairs. Another example was when a member of staff said, "Careful the kettle is hot," when supporting someone to make a cup of tea.

When an incident occurred people received safe care. These incidents had been analysed by management so that the risk of similar incidents occurring in the future was reduced. When a person became anxious and distressed they were redirected to do something positive that reduced their anxieties and reduced the impact on them and others.

People were supported by sufficient numbers of staff. The staffing levels were calculated on the level of support each person needed. Staffing levels were regularly reviewed and extra staff had been brought in when needed, for example for a specific activity. One member of staff said, "We have enough staff. We are really okay with staff." We observed staff responding to people's needs when required throughout the day. The staffing rota reflected what we saw on the day of inspection, which was two support staff during the day and one at night.

The provider had ensured that only fit and proper staff were employed to support people. Staff files included application forms, records of interview and appropriate references. Documentation recorded that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were

suitable to work with vulnerable adults and the right to work in the UK.

People were supported by staff who had received medicine training and an annual medicine competency assessment. People were encouraged to be as independent with the administration of their medicines as they could be. We observed that people were given the time needed to take their medicines safely. People had written protocols in place for receiving medicines on an 'as needed' (PRN) basis. These guided staff when and how to give the person these medicines, they were reviewed regularly. Staff checked that people had taken medicines before signing the medicines administration records (MAR) to ensure that records accurately reflected the medicines people were prescribed. Medicines were stored and disposed of in a safe way. Medicines were locked in a secure cupboard. The MAR charts showed all prescribed medicines were signed as being taken by staff trained to do so. We observed medicines being administered safely on the day of inspection.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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.

Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were not followed. When asked, the registered manager said all people lacked capacity to make certain decisions. Despite this the registered manager had not assessed people's capacity and they were unsure who had the legal authority to make decisions on behalf of people. This put people at risk of having decisions made for them unlawfully and against their wishes.

Some people had their freedom restricted to keep them safe as the front door was locked at night. People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this for a domiciliary care agency are called the Deprivation of Liberty Safeguards (DoLS) and applications are made by the funding authority to the Court of Protection. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made incorrect DoLS applications to the local authority. He then did not follow this up and find out how the DoLS process for domiciliary care agencies worked. There was no evidence that the funding authority were aware of the restrictions in place at the service. The funding authority was therefore unaware they needed to make applications to the Court of Protection on behalf of people. On the day of inspection because mental capacity assessments had not been completed and valid DoLS application had not been submitted people were being unlawfully restricted. When discussed with the registered manager they said they would contact the local authority to discuss the DoLS applications immediately.

Staff had a basic understanding of the MCA including the importance of gaining consent before commencing support. Staff however had limited knowledge of the formal processes that needed to be followed, including best interest meetings. Although decisions had not been made on behalf of people there was a risk of it happening. Staff were not aware of the DoLS in place to keep people safe at the service. One member of staff said there were no restrictions in place, whereas another one said, "I have heard of DoLS but do not know much about it." Since the inspection the registered manager has informed us that they will arrange training for staff to cover MCA and DoLS in more depth.

Due to the lack of understanding about MCA and DoLS and the risk decision could be unlawfully made for people his is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives said that all regular staff had the right skills and knowledge to give them the care and support needed. A relative said, "Staff come across well trained." A member of staff described the staff

induction as, "Fine. It covered everything from health and safety, needs of residents and shadowing sessions." All staff we spoke to said they had enough training to fulfil their roles. Training courses included safeguarding, food hygiene, fire safety and health and safety, which were a mixture of distance learning and classroom practical courses. One member of staff said, "I feel I have enough training. We also have refresher training when needed."

After reviewing the behavioural monitoring sheets for a person who had the potential to became anxious and distressed we asked the provider if they provide any behaviour and conflict management or physical intervention training for staff. We were informed they did not. Although staff felt they had the skills to support this person without training the provider ran the risk of not providing the right support which would not be in line with best practice. The provider also ran the risk of staff supporting this person inconsistently, which would further distress them.

We recommend that training needs for staff are reviewed in line with best practice guidance and the needs of individuals.

People were supported by staff who had regular supervisions (one to one meeting) with their line manager. These gave staff the opportunity to discuss their development and training needs so they could support people in the best possible way. A member of staff said, "I feel supported." Another member of staff confirmed they received regular supervisions and appraisals.

People's nutritional needs were met and they were given support to maintain a healthy weight. People were encouraged to learn new skills including making hot drinks and preparing meals. We observed a person being supported to peel potatoes. People had a meal of their choice at a time that suited them. People were supported by attentive staff who gave enough time for them to eat and enjoy their meals and checked if they wanted more. Staff were aware of people's dietary needs and preferences.

We observed lunch on the day of the inspection, which people enjoyed as they were seen eating all the food they had chosen. We observed staff encouraging people to maintain their independence during mealtimes but saw that they stepped in with practical support when needed. For example, staff were observed prompting a person to eat more slowly and chew their food more.

People had access to health and social care professionals, who helped maintain their health and wellbeing. Staff responded to changes in people's health needs quickly and supported people to attend healthcare appointments, such as to the dentist, opticians or doctor. People had their medicines reviewed at least annually. People with more specialised health needs had been referred to appropriate health care professionals. For example, a person had been referred to SALT, whereas another person had input from the audiological department.

People had health action plans, which helped monitor the health input they receive. People's care plans included information that enabled staff to monitor the well-being of the person. Each person also had hospital passports with their information if they needed to go to hospital so consistent care could be given.

Good

Is the service caring?

Our findings

People said that they were treated with dignity and respect. We observed examples of staff being mindful of people and respecting their dignity. When we arrived for the inspection a person was on the stairs in their underwear. We observed them being supported appropriately to their room to ensure their dignity was respected. We later heard a member of staff encourage the same person to put some clothes on if they wanted to go out.

Despite this we saw that staff did not always notice when people's privacy was compromised. A person who moved in three months ago had a bedroom on the ground floor. There was a windowed door separating their bedroom with the lounge. Although there was a curtain on the door to obstruct the view into the room staff did not ensure it was properly drawn while supporting the person getting changed. Therefore this person's dignity was not upheld. Although we feel this was a one off incident we recommend that staff take greater care in respecting people's privacy and dignity. Since the inspection the registered manager has informed us that staff have had strict instructions to make sure that the residents dignity and privacy are preserved by making sure that the curtains are drawn.

There was a family feel to Redroof House and the support provided to people. The registered manager and staff spoke of their 'extended family,' when referring to people. A person said, "We're like family." A compliment from a relative praised the, 'Redfoof family.'

During the inspection we observed people being treated as equals. We observed light-hearted conversations about who was going to make a cup of tea. A person said, "There is a bit of leg pulling but it's all a laugh." A member of staff said, "It's nice to see smiles on their faces."

We saw positive messages about the home in the compliment file. A compliment praised the, 'Extreme kindness and expert care.' Another described the staff as, 'Exceptional people.' A relative said, "X seems quite happy enough. I've never had any complaints about him being upset."

Our observations showed there was a caring culture amongst all staff and staff demonstrated they knew people well. During the inspection we saw that staff took the time to listen and interact with people so that they received the support they needed. People were relaxed in the company of staff. They were seen smiling and communicating happily often with good humour. Staff did not rush people; they took time to engage with them in a meaningful way. We saw staff giving reassurance to a person when they had eaten someone else's food by mistake. This was completed in a caring and compassionate way.

People were supported to express their views and be actively involved in decision making about their support. Staff were observed asking people questions able their day to day support needs. Staff were attentive to people's body language, particularly for people who were not able to communicate effectively, and checked with them if they had interpreted their mood or needs correctly. We saw that independent advocates were involved in helping people make decisions about moving to the service.

Staff involved people in the day to day running of the home, for example, laying the table, washing up, making cups of tea and preparing meals. People were actively involved in making choices about the decoration of their rooms, which gave a caring feel to the home.

During the inspection information about people living at the home was shared with us sensitively and discretely. Staff spoke respectfully about people, in their conversations with us; they showed their appreciation of people's individuality and character. Staff knew people's background history and the events and those in their lives that were important to them. Staff were very passionate. One said, "Residents make my work not feel like work. They brighten up my day. Everything is for them."

Relatives said they always felt welcomed at the service. One relative said, "We came for X's birthday. They bought him a cake and had a party." A member of staff said, "We always have a party for people's birthday's. They love it!"

The service encouraged and maintained long standing relationships. Previous people who lived at the service and relatives continued to visit people. Staff said the people really enjoyed this.

Requires Improvement

Is the service responsive?

Our findings

People were involved in choosing where they lived and appropriate support with decision making was arranged depending on people's needs. People were involved in planning their support. Before people's support commenced an assessment of people's needs was completed with people, relatives and people who were important to them where appropriate. This assessment covered areas such as health needs, mobility and medicines. This meant staff had sufficient information to determine whether they were able to meet people's needs before support started.

Once the person had moved in, a full care plan was put in place to meet their needs which had earlier been identified in the initial assessment. Our observations and people's daily notes showed support was being offered in line with care plans. For example, we observed a person was given time to process a question they were asked so they had time to make an informed decision about what they wanted to eat for lunch.

When people had specific support needs we saw there was guidance for staff. This guidance however sometimes lacked information on the best ways of supporting people when they were at risk of becoming distressed. We saw that there was no agreed way of supporting a person who had recently moved to the service when they became distressed. Although staff said they felt comfortable supporting this person the lack of clear guidance put the person at risk of receiving inconsistent support when they were anxious. Despite the service only using permanent members of staff the registered manager said this person was still settling in and they were still getting to know them. We saw from records that this person had regular incidents where they became distressed and anxious putting themselves and others at risk. When discussed with the registered manager he agreed that clearer guidance should be in place for staff.

Support plans were not always written in the most dignified and person centred way. People had person centred plans (PCP) which stated people's 'Gifts and qualities.' In one person's it stated that one of their gifts was, 'I have got challenging behaviour.' Another person's PCP stated their gift was, 'I am always impatient.' Other descriptions of this person used words such as, 'Anger,' 'Jealously,' and 'Bossy attitude.' The support observed on the day was not reflective of this terminology and the daily notes were written in a respectful manner this reduced the impact of these inappropriately worded support documents. We spoke to the registered manager about the terminology used and he said he was not aware these words had been used in people's support documents.

We recommend that support guidelines and support plans are reviewed in line with best practice guidance and the needs of individuals.

People's choices and preferences were documented and staff were able to tell us about them without referring to the care plans. There was information concerning people's likes and dislikes and the delivery of care. For example, one person enjoyed looking after their guinea pigs and another loved music and dancing. Staff knew this information and were seen engaging people in these interests on the day of inspection.

People were encouraged to be as independent as they could be. Staff understood people's abilities and the

best ways to motivate them to be involved. For example, we observed one person responded very well to gentle encouragement. People were encouraged to self-administer their medicines, prepare meals and access the community.

When a person's wellbeing changed they received input from their GP, psychiatrist and community nurse. The service monitored their mood and informed professionals of any incidents and concerns so they could respond appropriately. We saw from records that the person's medicines had just been reviewed to respond to their changing needs.

The registered manager ensured that people's weight was monitored so staff could respond to any changes of health needs. All information relating to people's health and wellbeing was recorded in their health action plan, which was kept up to date and had specific person centred information on people's health needs. For example, one person needed particular support to maintain their skin integrity, including the use of specialist stockings and creams. When we asked staff were clear how to support this person in line with their guidance.

Feedback from people and their relatives was sought. People were supported to fill in an easy read satisfaction survey. The survey focused on what they thought of their support and if they were appropriately supported by staff. The results were very positive. All next of kin had completed a recent service survey that focused on all aspects of their visit to the home. The surveys included questions such as, were staff approachable and were people treated with dignity and respect. The survey also gave an opportunity for relatives to comment on their overall feedback on the home. All questions were answered as 'Very good.' The registered manager informed us that if there were concerns that were raised in either satisfaction survey then an action plan would be implemented to improve the service provided.

The service had regular meetings where people were encouraged to speak about things that mattered to them. In the last meeting activities, haircuts and people's relationships with each other were discussed.

People and relatives were made aware of their rights by staff who had an understanding of the organisation's complaints procedure. People and relatives knew how to raise complaints and concerns on behalf of people. All people and relatives we spoke to said they had never needed to make a complaint and were happy with their support as it met their needs. There had been no complaints in the last year. The registered manager informed us that if a complaint was received they would be taken seriously by the provider and used as an opportunity to improve the service.

Requires Improvement

Is the service well-led?

Our findings

People and relatives spoke of the service in high regard. Despite this there was a lack of quality assurance systems in place. Quality checks were in place for health and safety. The registered manager had completed a one off 'dignity in care audit', which we were told was completed in 2015. Although the health and safety audit ensured that tasks were completed on time there was nothing in place to review and assess the quality of the overall support provided. There were no systems in place to drive continuous improvement within the service.

Due to the lack of quality assurance systems the registered manager was unaware of some issues that impacted on people's lives. For example, there was a lack of staff training and guidance in regards to supporting a person when they got anxious and distressed. This person was a risk of inconsistent support being provided. Care plans were sometimes written in an undignified manner and there was no medicine audits taking place. When discussed with the registered manager and business partner they came to realise there was a gap in the quality monitoring of the service. They said they would implement a robust auditing system.

When actions had been highlighted to improve the service they had not been completed. For example, the only action in the 'dignity in care audit' in 2015 was to design a pictorial complaints procedure. This had not been completed.

The registered manager had not implemented robust quality assurance systems and failed to complete highlighted actions to improve the service. This led to the registered manager not identifying the improvement needed for the service to comply with The MCA. This is a breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager failed to submit a PIR before the inspection. The registered manager and business partner said they would look into the reasons for this but did not give a valid answer. Submitting a PIR on time is a requirement for any service that is registered with CQC so that an inspection can be effectively planned. There were also three separate safeguarding issues that had not been notified to CQC. When we raised this with the registered manager they did not realise they needed to inform CQC of such incidents. This meant that CQC could not effectively carry out its role of monitoring and regulating this service safely.

This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

The service had a positive culture that was friendly and caring. Relatives told us that the registered manager and staff knew people well. This was made evident on the day of inspection. The registered manager told us about the home's missions and values of 'fulfilling lives, being happy and fulfilling potential.' Staff we spoke to understood the values and ensured people received kind and compassionate care. A member of staff said, "We are here to make people be independent. To set goals they can achieve and have relationships with their family."

Staff were involved in the running of the service. Team meetings were used in an effective way to concentrate on important themes when they arose such as people's changing health needs. Staff were given the opportunity to raise concerns in these meetings, which were followed up my management.

Throughout the inspection people felt comfortable approaching the registered manager with questions they had about their support. The registered manager gave time to answer these requests. The registered manager interacted well with people and was observed giving people time to have a chat. We observed this interaction reduced people's anxiety and was welcomed by people.

Staff praised the 'team sprit' describing it as 'brilliant' and 'lovely'. Staff agreed that the registered manager was approachable one person said, "If I have any worries I would speak to the registered manager."

The management team had an inclusive communicated well with people, relatives and staff. Observations on the day showed that the registered manager communicated clearly and effectively with people and understood their individual needs. All relatives we spoke to agreed that communication with the home was good.

People and relatives felt that they could approach the management team with any problems they had. Members of staff agreed that the registered manager was approachable. One member of staff said, "Management is very good. They are helpful to us staff and service users. They consider what we say and they take it on board." Another member of staff said, "Management encourage and support us."

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
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to submitted notifications to CQC after incidents occurred that were referred as safegaurdings.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff lacked knowledge of MCA and DoLS. DoLS applications need to be made for restrictions in place.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of robust quality assurance systems so shortfalls in service delivery were not identified. Highlighted actions had not been completed.