Miss Bridget Jane Marshall

Miss Bridget Jane Marshall - 43 Freeman Street

Inspection report

43 Freeman Street
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Tel: 01328710140

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place 7 February 2018 and was unannounced. The last inspection to this service was on 4 May 2016 and we rated the service as good in each key question. However, since October 2017 we have reviewed and refined our assessment framework. Under this new framework, a number of the key questions have been extended to include different key lines of enquiry.

43 Freeman Street 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. This service provides residential accommodation for three adults with a learning disability. They live with Miss Bridget Jane Marshall who is the registered provider/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 service represented an extended family and people at times referred to the registered provider/manager as 'Mum'. People took comfort and support in being part of an extended family and had lived as a 'family group' for many years. In terms of the scope of registration, the service had been registered as a residential home and was therefore expected to meet regulations laid out by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found seven breaches because there was an absence of systems, and audits, which underpinned the health, safety, and well -being of people that used the service. The registered provider/manager supported people with their day-to-day activities and recorded people's needs in a set care plan and daily diary, which were reviewed at least annually. However, we were unable to see how the manager worked collaboratively with others and sought their views about the care they provided. Feedback from people and their families was sought as part of on-going communication but not always recorded.

The registered provider/manager had not informed us and did not show us records relating to a number of incidents, which had occurred at the service. They are required to notify us of specific events affecting the wellbeing and safety of people using the service. This helps us make a judgement about the service and helps inform our inspection schedule. We might bring forward inspections based on information received. It helps the provider to demonstrate they have taken effective action when people have been injured or involved in incidents that have caused them harm. We look to see if the provider had systems in place to identify and mitigate known risks and how they keep people using the service, staff and visitors informed about how they are learning and limiting reoccurrence. This also involves a 'duty of candour' when investigating such matters. Without this information, we could not be assured that actions taken to keep people safe from risk, and or harm were sufficiently robust. Information was not shared on a need to know basis with family members and people's wider circles of support.

The key question about staffing was not applicable at this inspection as the registered provider/manager

was the sole staff member. However, the provider's partner was also in the household and we asked the registered provider/manager for a copy of their disclosure, and barring check. Following the inspection the provider sent us evidence that a DBS had been applied for both themselves and their partner.

The service was sufficiently clean and people were having their needs met in relation to a safe environment.

People were prescribed medication and the registered provider/manager administered these along with their partner who assisted at times. The provider/manager told us they were trained to undertake this but their partner had received no training. Although there were records of the medication people took and when it was administered there were no audits or stock checks in place so we could not see if errors had occurred.

The Registered provider/manager did not provide us with any evidence of training but were knowledgeable about people's needs. However without regular training and the opportunity to meet others and share ideas and gain mutual support we did not know how the registered provider/manager was keeping up to date with legislation and best practice.

People were supported to eat and drink enough for their needs and there was some monitoring of people's weights. The registered provider/manager took people to see their GP if there were any concerns about their health. However, other professionals told us appointments had been cancelled and routine appointments with other health care professionals were not always kept.

The manager understood legislation relating to mental capacity and told us people were involved in decisions about their care and welfare. Mental capacity assessments were being completed by the Local Authority to help support people in light of the proposed house move to another part of Britain. The registered provider/manager said mental capacity assessments had been completed in the past but there was no evidence of this.

The service ran like an extended family and people had established relationships with each other and with the Registered provider/manager. People were supported to keep in contact with their own families and involved in day-to-day decisions. We could not ascertain if people's independence was fully facilitated or that people were encouraged to live lives as others do and take responsibilities within their capabilities.

Care plans and daily notes gave us an insight into people's needs and how these were being met. These were kept under review. The care plans did not record what people's aspirations and goals were and steps towards achieving these. The terminology used was sometimes restrictive.

Feedback about the service was limited. People felt able to raise concerns to the registered provider/manager and had contact details for the Local Authority. We were not confident that all information that should be shared with us had been which reduced our confidence in the provider.

The service was difficult to assess against regulation because there was a lack of paperwork providing a good audit trail. However, people appeared to be very happy in the service and the registered provider/manager was confident they were meeting their needs.

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 than12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Notifiable incidents had not been reported to us, which made it impossible for us to assess any ongoing risks to people using the service.

Staff were not employed at this service, which meant people were not able to have one to one support around their individual needs.

There were no contingency plans for people using the service should the registered provider/manager be unable to continue to support people living in the service.
The provider/manager administered medicines but there were no audits or stock checks so we were unable to see if people always got their medicines as required.

The premises were clean and fit for purpose.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider/manager could not demonstrate that they were up to date with training necessary for their role.

People were seen by their GP as required but people had not always seen other health care professionals as required. .

People made decisions about their day-to-day lives but the Local Authority were in the process of establishing

Is the service caring?

Requires Improvement

The service was mostly caring.

The people using the service did not have full control and autonomy over their lives.

Records focused on what they needed support with without providing evidence of enablement and person centred care

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People received care and support around their needs but it was not evident how they were being supported to be independent

People could raise concerns but it was not clear if these would be responded to adequately.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor and improve the quality of care provided were not robust.

This service was not meeting all the care home regulations and there was no plan in place to address this. .

We took into account people's experiences, which were positive.

Miss Bridget Jane Marshall - 43 Freeman Street

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 was planned to check 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.

The Local Authority made us aware of an incident that occurred at the service just after Christmas. Although individuals did not suffer any harm, we decided to bring our comprehensive inspection forward to ensure the wellbeing of people using the service.

The inspection took place on 7 February 2018. The inspection was unannounced in line with our methodology.

Two inspectors carried out this inspection after some additional concerns were received. Before the inspection we had very little information or feedback about the service. We have not received any notifications. We did not have a provider information return, which is information from the provider about what the service does well, and improvements they plan to make. Previous inspection reports were viewed and showed the service has always been rated as compliant with the regulations and rated Good overall at our last comprehensive inspection. However, we had not been aware of previous incidents and safeguarding concerns identified as part of this inspection.

Before the inspection, we spoke with members of staff from the Local Authority safeguarding team and Quality improvement team. During the inspection, we spoke with the three people using the service and the Registered provider/manager. We looked at people's medication records, care plans and the diary.

Inadequate

Is the service safe?

Our findings

During this inspection, we had a number of concerns about the welfare and safety of people living at the service. Prior to this inspection we were made aware of an incident which was followed up by the Local Authority safeguarding team. No harm came to people using the service but it raised concerns about the actions of the registered provider/manager. There had also been concerns voiced by a number of local people. Although satisfactory explanations were offered, nothing was recorded of alleged incidents making it difficult to investigate or substantiate. During our inspection, which we brought forward because of the concerns we found, the provider/manager was open and honest with us and told us how they had been communicating with the Local Authority with regards to a specific incident.

In discussion with the registered provider/manager and from the records we looked at, we saw a number of specific incidents had occurred at the service and in the community some dating back to 2012. The registered provider/manager had failed to notify us of the incidents as required by our regulations. Failure to notify us about significant incidents where people had sustained injury or were at risk of harm meant that we had not been able to accurately monitor the service and identify any patterns relating to risk.

The registered provider/manager did know people extremely well and was aware of risks to their individual safety. They took reasonable actions to prevent risk but did not always document their actions. People had some restrictions in their daily lives justified by the level of risk this might pose. For example, the pantry was shut but people had access to kitchen cupboards. The front door was not used due to the risk of traffic both to one person who had some memory issues and for the safety of the many pets living at the service, the people living at the service were not aware of any unnecessary restrictions. One person said they needed supervision to use the oven but could prepare hot drinks and simple snacks .

We accompanied a person out and they were able to access the community safely including crossing the road. Two of the three people went out locally unaided. Records at the service did not identify all risks and how they were managed. For example, one person had a movement disorder, which had on one occasion caused them to fall on the stairs. There was no risk assessment in place for this. There was little further information about this and how this might affect the person outside of the service. We also noted there were no records relating to the risks posed by substances such as the chemicals stored on the allotment. The provider informed us this was a herbal treatment which they decanted into used containers for a household cleaning product.. We were not assured this was safe to use and safe to be stored in such large quantities as there were no risk assessments or data hazard sheets.

The above supports a breach of Regulation 12. Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We asked people about their finances and it was clear people had their own accounts and could access their money with support. The registered provider/manager held their bankcards. People told us they could save up for, or purchase things they wanted but the registered provider/manager had responsibility for the money. There was discussion about the provider/manager 'loaning' people money. We questioned this, as

we believed the money being 'loaned' was people's own money. We established the registered provider/manager paid for everything and then reimbursed herself. We have asked the registered provider/manager for a breakdown of monies and income and expenditure. They kept an overall spread-sheet and separate finance books with receipts but this had not been totalled up for a long time so it was not possible to see if records were accurate. We also asked the registered provider/ manager why it was necessary for them to manage the monies. We felt it might be in everyone's interest if people had someone appointed by the Local Authority to manage their monies rather than the registered provider/manager. They agreed this would be a good idea and said they would look into it.

The registered manager knew who to contact if they had concerns about people living in the service and said they had referred any safeguarding matters on to the Local Authority. During this inspection, we became aware of some incidents we had not been previously aware of..,. We have written formally to the registered provider/manager to ask for more information to help us understand what actions were taken at the time. Our concern was that record keeping was not sufficiently robust and CQC had not been informed about specific incidents, which meant we were not given the opportunity to respond.

The registered provider/manager told us they had completed training in protecting vulnerable adults from abuse but could not confirm when they last updated their training or how they kept themselves up to date with changes in best practice and, or legislation. This meant we were not assured that the registered provider/manager was fully aware of their responsibilities to report and take other actions as instructed.

At the time of our inspection, no other person was employed to support the people living in the care home. The registered provider/manager lived at the home with their partner. During our inspection, we requested copies of both theirs and their partners disclosure and barring checks to which the registered provider/manager said these would have been supplied at the time of their registration. They confirmed that their partner did have a DBS and they would send us a copy. We also asked for a copy of theirs. We had not received these three days after our original request so we have made a formal request in writing. The provider has since sent confirmation that they have applied to the DBS for both themself and their partner.

The above supports a breach of Regulation 13: Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider/manager and her partner carried out all care tasks with no help from other employed staff. Although this worked well for most of the time we were aware that at times this had posed difficulties and we could not be fully assured that staffing, arrangements would always be in place to keep people safe. There was no recognised contingency plan for if the manager/provider became unwell or needed to be away from the service. Whilst her partner was clearly very involved in the business and appeared to have good relationships with the people who used the service, he was not trained or employed to provide care and support. The registered provider/manager had not sought to establish a relationship with an agency or develop an alternative source of appropriate support to provide cover. This would mean in an emergency any arrangement could be 'ad hoc' and therefore not robust. The people using the service would also not be accustomed to the staff providing such emergency cover and this could be unsettling for them.

The above supports a breach of Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People took regular medication. The registered provider/manager administered medicines. There were records to show what medicines people were taking and a signature indicated when medicines been administered. However, there was no stock control, i.e. quantities of medicines carried over from one record

to another. Medication audits were not completed and we saw no medication protocols for prescribed when necessary medicines. We were unable to see if people had consented to take their medicines or were able to safely.

The registered provider/ manager told us they had completed medication training but was not able to provide us evidence of this or tell us how recently they had done this. They also confirmed their partner occasionally gave out medication for which they had received no training.

People using the service for various reasons had not always attended reviews with other health care professionals. However, the registered provider/ manager assured us that people saw their GP regularly and had their medicines reviewed annually. We saw some documented evidence of visits to the GP but not specifically in relation to medication.

We noted in a person's record that prior to them moving to the service they use to take their own medicines. We saw no process in place to assess and support people to take their own medication and to help them be more independent.

The premises were well maintained and clean. We had no immediate concerns as everything visually looked in good repair. We did not request maintenance or cleaning records as part of this inspection but relied on observational evidence. Equipment was replaced as required and people using the service confirmed this. There were multiple domestic pets at the service.

Requires Improvement

Is the service effective?

Our findings

There was some evidence that the registered provider/manager consulted with other health care professionals when appropriate to do so. However, this was mostly with the family GP who they sought advice from as appropriate. There was some evidence that many health appointments had been missed and rescheduled so we could not be assured that people's needs were being fully met and there was poor documentation about people's health care needs. For example, one person was on medicines for epilepsy but their records also showed they had not seen a neurologist since 2013.

We found that people's complex health conditions were not being regularly monitored or managed by specialists and there had been many missed appointments. Most of people's health-care was being overseen by the GP only. The decision to do this had been taken by the provider/manager but it was not clear that this was in people's best interests.

The above supports a breach of Regulation 9. Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us the registered provider/manager took them to their health care appointments. One person gave an example of when they had been to the GP recently and had been prescribed some tablets.

The registered provider/manager had a lot of experience and had been supporting people in their own home for many years and did not employ any staff. They told us they had a level five care qualification. They told us they had done all the relevant mandatory training over the years, both face to face and e-learning refresher training. They were not able to give us any examples of training they had completed recently or how they kept their knowledge and practice up to date. When asked they said 2016/17 was the last time they had done any training.

People using the service said the manager knew their needs and the registered provider/manager was able to describe in detail people's needs including any long-term health care conditions, which might need additional monitoring, or other health care interventions. However, there was limited evidence of how the provider engaged and acted upon health care professional's advice.

We have asked the provider/manager formally to provide us some evidence that they are keeping their knowledge and skills up to date to enable to continue to support people appropriately. To date we have received copies of certificates completed in 2016 for some but not all the mandatory training we would have expected the provider to complete. However, they have said they will supply additional information.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

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 were being met.

The registered provider/manager told us no one living at the home had a DoLS or needed one. They said people had access to the community. At least one person required a lot of supervision to help keep them safe, as they were not always aware of their immediate surroundings or risks to their immediate safety. The registered provider/manager has recently confirmed they are moving to a different country. Part of the process for this is a period of consultation with people using the service and their family. The Local Authority will complete mental capacity assessments to establish if people are able to make decisions and are aware of all implications of moving address.

People we spoke with were very positive about a move to Scotland and were keen to assure us that they understood the implications of such a move.

People were not aware of any restrictions placed on them by the registered provider/manager and said they had opportunities to go out and be involved in regular activities. We were not able to establish if people were able to do more for themselves than they were currently doing such as managing their own money or medication for example because their needs and abilities in these areas had not been assessed.

People freely made themselves drinks and snacked on biscuits. All the people using the service told us they were involved in meal preparation and shopping which they purchased mostly on line. They grew some vegetables in the allotments; the household was somewhat self- sufficient. Food was freshly prepared and home cooked. The registered provider/manager and a person using the service told us about an incident where they had almost choked because they put too much food in their mouth. The person told us they were supervised and their care plan stated they needed support with their meals.

There was some monitoring of people's weights and we saw one person had lost a fair amount of weight. However, this was purposeful and the registered provider/manager had taken people to the doctor to check the body mass index to assure their weight was appropriate to their height, which it was. The registered provider/manager told us about one person who had been overweight when they first used the service and had a poor life style but said now they were the right weight and a lot healthier. The person agreed with this.

Requires Improvement

Is the service caring?

Our findings

The interactions between the registered provider/manager and people were observed and were inclusive. The registered provider/manager clearly knew people well and cared about them and their welfare. She asked them to comment throughout the inspection about their thoughts and feelings. Inspectors were able to speak with people alone throughout the day, which could have been difficult as they all congregated in the one room. One person was happy for us to come to the allotments with them and talk to us about the pending move and how they found living at the home. Another showed us their room and did not raise any concerns with us. A third person made tea for us and told about a previous incident of concern. They were accepting of the situation and were aware of who to contact should they need to.

People did not seem ill at ease but it was clear people had some anxiety about our visit and previous visits from the Local Authority. They wanted assurances that we were not going to share personal information and said they were keen to move. The main reason given was the new home would be quieter than where they currently lived.

We found on occasion that the provider/manager hampered relaxed communication by interrupting and steering the conversation. This was not commented on by the people who used the service but we noted an element of control over people's ability to communicate freely at times.

We spoke about the relationship between all of them and they clearly saw themselves as a family group. They told us about other members of their extended family who they had some contact with. They told us that once they moved their relatives could stay in contact and come and visit. We confirmed that no one had their own mobile phone or social media account but spoke about ways they could stay in touch currently and in the future. We felt their opportunities to stay in touch with family members could be enhanced particularly where family members were not able to travel due to ill health.

People were involved in their care and support but the care plans and reviews we saw did not set goals to be achieved to help people be more independent and to broaden their life experiences. Care plans also used judgemental language in the way people's behaviours and needs were described. Some of the language used in records was restrictive and punitive such as, 'told off.', which was more reflective of an adult- child relationship. We also noted external contractors moved freely around the house and did not seek people's permission to go into rooms. This was people's homes and they should have been consulted.

Requires Improvement

Is the service responsive?

Our findings

We asked people about their likes and their achievements since living at the home. One person said they had grown in self- confidence and could stick up for themselves. Another felt their confidence had also grown and they pursued a healthier life style. A third person said they ate hardly anything previously and now ate most things.

In discussion with the registered provider/manager, it was clear that the people being supported had experienced some difficult situations in the past before coming into a family environment. We felt people did not have enough opportunity outside the home environment. We looked at care plans and statutory reviews, which were held with the Local Authority. These focused on day-to-day skills and tasks. We could not see an emphasis on what the person would like to achieve and if they had any aspirations and goals for the future. We might expect people as able as those we met to be pursuing different hobbies and interests, developing friendships and relationships and managing their own monies and medication. It was difficult to assess this as the documentation we viewed focussed more on behaviour and risk. We saw what support people needed rather than what people had achieved or what would enable them to be more independent. For example when we asked if people could be 'home alone' we were told no this was not appropriate. This meant that if the registered provider/manager had any appointment they either had to rely on their partner to provide support or take people with them. We could not see if the registered provider/manager had assessed the risks of people being alone or considered what might help people to be able to be alone safely.

Care plans were sometimes written in a way to describe something as a problem rather than looking at a situation objectively and describing what support a person needed to relieve their frustration, anxiety or to help them develop appropriate relationships and feelings.

People did have interests and clearly liked being outdoors, working on the allotment, feeding the chickens and growing vegetables. The registered provider/manager worked with boats and this was an interest shared with people living at the service. In addition, the registered provider/manager had dogs, cats and parrots. People clearly enjoyed having the animals and walking the dogs. One person had tropical fish and was knowledgeable about them. Another spoke of guinea pigs. Regular holidays to Scotland were undertaken but we did not get the sense that people pursued individual activities outside the 'family's interest.'

The registered provider/manager said people did not like attending day centres and they provided activities for people including a tennis club, which had appropriate adult supervision. The registered provider/manager had identified that people needed supervision and as a sole carer was not able to provide one to one activities unless their partner could support. The Local Authority had told us that funding could be available for some 1-1 support but the registered/provider had not taken advantage of this. We felt from speaking with people that they could do more without supervision. During our visit, one person went to the allotment and then when they came back went to the local shop but the other two stayed in throughout our visit and when we asked if there was a plan for the day they did not think there was.

People could not tell us of anything they did outside the home. People did not attend day centres, have any supported employment or attend regular clubs. This reduced their opportunities to meet people of a similar age and that had similar experiences. The registered provider/manager said it was a busy household and people did not get bored. There was always plenty to do.

By doing most things, together people did not have the same opportunity afforded to other adults. The registered provider/manager said two people went out independently, locally whereas the third person needed more support to ensure their safety. Daily notes indicated people going to local events, working on the allotments and going to the nearby beach. People said they enjoyed this as well as regular holidays to Scotland. However when we asked if people had been to the cinema, bowling or other such activities they told us they had not. We felt people could be enabled to do more.

This is further evidence of a breach of Regulation 9. Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People being supported were young but there was nothing recorded about their preferences should they become ill, need treatment or their preferred priorities of care should they become terminally ill. It is important to establish their wishes so when necessary their wishes could be upheld.

It was difficult to establish what people would do if they were unhappy with the service they received. People had contact with family but were reliant on the registered provider/manager to support them to retain contact with family particularly where one family member was poorly. People did have access to a regular social worker who had completed annual reviews and people knew their contact details and had contacted them directly in recent weeks. However, from speaking with people they were not entirely confident with social services and looked to the registered provider/manager for their support and advice. We had concerns about this because during this inspection, we found the registered provider/manager had not always shared information with us, as we would expect.

Inadequate

Is the service well-led?

Our findings

The difficulty we had when inspecting this service was that to all intent and purpose this was a family home, which did not have staff employed to provide the care and support. The registered provider/manager undertook all the support and kept records, as they felt necessary including care plans, and medication records. There were no other records available for us to inspect. For example, there were no audits and no feedback from families or health care professionals collated by the registered provider as part of the quality assurance system. The Registered provider/manager said they routinely spoke with families and as such did not feel it necessary to record every interaction. We were not assured that family members were kept up to date with incidents in the service. We were notified of an incident which occurred in December 2017 which had not been shared with family where people had been put at potential risk.

This evidence supports a breach is regulation 20: Duty of candour. Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered provider/manager knew people well and felt able to anticipate and meet their needs. They involved people in discussion and encouraged them to speak up and give their opinions, although at times we felt they steered the conversation. They were contemplating moving on to a different area of the country and had a lot to complete. The registered provider/manager did not have time off but should they need to it was not clear what contingency plans would be put in place. We could not be assured in this situation that people's care would be delivered as required. The registered provider/manager said they could employ someone. However, they had no links to local agencies established or strategies in place for now or in the future. Partnership working of all kinds was not successful and, apart from a good relationship with the local GP service, few professionals were involved in helping the provider/manager meet people's health and social care needs.

We found gaps in records and the information we needed could not all be provided. We identified through discussion, a number of incidents and safeguarding concerns, which had not been reported to us. The Local Authority told us they were also not aware of some of the concerns. Without having sight of the original documentation, we were unable to establish what if, any actions the registered provider/manager had taken and to whom they may have reported concerns. Without a clear audit trail, it was difficult for us to establish if the registered provider/manager was operating within the requirements of a regulated care service.

This evidence supports a breach of regulation 18 Notifications of other incidents. Care quality Commission (Registration) Regulations 2009.

Without audits or adequate records, we were unable to see how the registered provider/manager received support or kept themselves up to date so their knowledge was current and reflected the changes within health and social care. We found that the parental role the provider/manager took, whilst clearly caring, was not always appropriate for the young adults at the service and we could not be fully assured that all aspects of the service were operating appropriately and safely as systems were not in place to enable us to check.

This evidence supports a breach is regulation 17: Good governance. Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 The service had failed to notify us of significant events/incidents, which had affected the safety, and well -being of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not ensure people had enough information, access to health care as needed to monitor their ongoing health and wellbeing. Care-plans did not support a personalised approach to care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to properly mitigate against risk because there was poor monitoring of people's needs and information about people's well being and safety when compromised was not shared with other Authorities.

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 service did not have adequate systems in place to protect people. Incidents had not been properly recorded and reported so they could

be properly investigated.

Records about people's finances did not show how these were audited adequately to show income and expenditure for each individual.

Disclosure and barring checks were not produced when requested.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems in place to demonstrate how they monitored and measured the quality of the service. Accurate, complete and contemporaneous records in respect of each person were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service did not open in an open and transparent way or share information as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not have adequate arrangements in place to ensure people had continuity of care should the provider not be able to meet their needs even for a temporary period of time or in the event of an emergency.