Rainbow Homes London Limited

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Inspection report

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Date of inspection visit: 02/09/2015
Date of publication: 13/10/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

The company Rainbow Homes London Limited operates this one care service that is registered with the Care Quality Commission. The services provided at this care home include for people with mental health conditions or substance misuse problems, and is primarily aimed at younger adults. The care home is for up to six people. There were three vacancies at the time of our inspection.

We carried out a comprehensive inspection of this service on 10 December 2014. We found eight breaches of legal requirements, which put people using the service at significant risk of receiving inappropriate or unsafe care. You can read the report of this inspection, by selecting the 'all reports' link for this service on our website at www.cqc.org.uk

We took enforcement action against the registered provider as a result of the findings of that inspection.

We undertook this unannounced comprehensive inspection, of 02 September 2015, to check on the progress the provider had made to address our concerns from the previous inspection, and to check on the standard of care people using the service were receiving.

Summary of findings

There was no registered manager in post on the date of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. A new manager had been appointed. They had applied for registration as manager of the care home; however, this process had not been completed. They were not present during out inspection visit.

Whilst we found evidence to demonstrate that some of our concerns had been addressed, we found breaches of 12 legal requirements because improvements were insufficient and further concerns were identified. This continued to put people using the service at unnecessary risk of receiving inappropriate or unsafe care.

The improvements made at the service were mainly in respect of the approach of staff who we found to be more caring and positive towards people than previously. Staff communicated better with people, and there was a positive, inclusive and empowering culture at the service. As a result, people using the service were more relaxed, and those we spoke with praised the services provided.

However, a staff information handover took place with a person using the service present. This compromised the person's dignity and the privacy of information about other people using the service.

There remained risks to people's health, safety and welfare as a result of the service's approach to people's individual health, safety and nutritional needs and risks. The advice of relevant healthcare professionals such as dietitians was not always promptly sought in response to risks such as significant weight change, and where advice was provided, timely care planning and action did not always take place in response.

People's individual risk assessments and care plans were not comprehensive or kept up-to-date to reflect people's current needs. Monthly progress reviews did not consistently monitor and evaluate all goals set up in people's care plans. This put people at risk of receiving care and support that was not appropriate or did not meet their needs.

There were improvements to medicines management; however, there remained risks to people being supported to receive their medicines safely.

Some fire safety equipment was not properly maintained, and there was a lack of recent fire safety checks, which meant that fire safety risks were not being safely managed.

People's health, safety and welfare were compromised due to a range of ineffective processes for assessing, monitoring and taking action to address risks and quality shortfalls. Records, particularly for the care and support of people, were not always accurate or complete. There was overall poor governance at the service.

Recruitment procedures had not been operated effectively to ensure that staff members were of good character, because appropriate references were not in place. Systems and processes to prevent abuse of people were not being effectively operated because whistle-blowing procedures were not properly established.

The support, supervision and training of staff was not appropriate to enable them to carry out their care and support duties effectively. Staff lacked sufficient training on meeting the needs of people using the service in respect of nutrition and mental health needs, and they were not receiving regular supervision.

Whilst the service was not unlawfully depriving anyone of their liberty, the provisions of the Mental Capacity Act 2005 were not being followed in full at the service, as people's capacity to refuse some specific support that might reasonably be seen as in their best interests had not been assessed.

We had not been notified as required of a change of company director and two separate police visits to the service, and we found that the required display of the rating from our previous inspection was not occurring. This undermined our confidence in the management of the service.

We found overall that people using the service continued to be at risk of receiving inappropriate or unsafe care. We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulations 2009.

Following this inspection we continued with our enforcement action. The action we took was to serve a notice proposing to cancel the registration of the

Summary of findings

provider. Due process was followed and we served a Notice of Decision to cancel the provider's registration which meant that Rainbow Homes London Limited was closed by the Care Quality Commission on 18 December 2015.

Summary of findings

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 remained unsafe. Some fire safety equipment was not properly maintained, and there was a lack of recent fire safety checks, which meant that fire safety risks were not being safely managed.

We found instances where risks to specific people using the service were not safely managed, including for nutrition and smoking. Individual risk assessments were not comprehensive or kept up-to-date to reflect people's current needs.

There were improvements to medicines management; however, there remained risks to people being supported to receive their medicines safely.

Recruitment procedures had not been operated effectively to ensure that staff members were of good character because appropriate references were not in place.

Systems and processes to prevent abuse of people using the service were not being effectively operated because whistle-blowing procedures were not properly established.

Is the service effective?

Inadequate

The service remained ineffective. There was inadequate nutritional support of people to sustain good health, despite clear nutritional risks to individuals. Where the advice of healthcare professionals was sought in relation to this, the service did not ensure timely responses to the advice, which did not support people to sustain good health.

The support, supervision and training of staff was not appropriate to enable them to carry out their care and support duties effectively.

The provisions of the Mental Capacity Act 2005 were not being followed in full at the service, as people's capacity to refuse some specific support that might reasonably be seen as in their best interests had not been assessed.

Is the service caring?

Requires improvement

The service was inconsistently caring. The approach of staff towards people using the service was more positive and respectful overall, and as a result, people using the service were more relaxed. There was also improved communication from staff towards people.

However, a staff information handover took place with a person using the service present, which failed to uphold people's privacy and dignity.

Summary of findings

Is the service responsive?

The service was not consistently responsive. People's care plans were not kept consistently up-to-date and accurate, which put people at risk of receiving care that was not responsive to their needs. Monthly progress reviews did not consistently monitor and evaluate all goals set up in people's care plans.

The service had an accessible complaints procedure, and people were routinely asked their views on aspects of the service.

Requires improvement

Is the service well-led?

The service remained not well-led. People's health, safety and welfare were compromised due to a range of ineffective processes for assessing, monitoring and taking action to address risks and quality shortfalls.

Records, particularly for the care and support of people, were not always accurate or complete. However, there was evidence of a positive, inclusive and empowering culture at the service.

We had not been notified of a change of company director and two separate police visits to the service, and we found that the rating from our previous inspection was not displayed in the service. These were legal requirements that the provider failed to adhere to.

Inadequate

Rainbow Homes London Limited

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.

This inspection took place on 02 September 2015 and was unannounced. The inspection team consisted of an inspector and a specialist professional advisor who specialised in food and diet of people with mental health needs.

Before the inspection visit we reviewed the information we held about the service including notifications, information from the local authority, and information the provider had sent us.

During this inspection we spoke with two people who use the service, three staff members and the registered provider's director. We watched the care and support being provided to people in communal areas, and looked around the premises. We reviewed all three people's care records that lived at the service and looked at records relating to staff employment, training and support, and the management of the service.

After the inspection we obtained the views of four community professionals involved in working with people using the service. The service's management team also provided us with further documents at our request.

Inadequate

Is the service safe?

Our findings

At our previous inspection of 10 December 2014, we found that risks to individuals were not safely managed. Although staff knew how to recognise the signs of abuse they did not understand who this should be reported to outside the organisation. People's medicines were not stored correctly. Staff who dispensed medicines did not have the skills to do this safely and people were at risk of receiving the wrong medicines. Equipment was insufficient to accurately take people's weight. Staff were employed without suitable checks being undertaken to ensure they were safe to work with people. This meant the provider was in breach of regulations 9, 11, 13, 16 and 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we found that there was insufficient evidence of improvement for these areas of concern, and that new safety concerns had emerged. This continued to fail to protect people using the service against the risks of unsafe care and support. This was now breaches of regulations 12, 13 and 19 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe using the service. However, we found instances where risks to people using the service were not safely managed. The deputy told us that one person smoked in their room by the door to the garden. There was no risk assessment about this practice available in the person's care file. We found that the matter had previously been raised by the local authority for urgent action on their monitoring visit of 12 August 2015. Following our inspection visit, the deputy sent us an updated risk assessment dated 08 September 2015 which considered this risk. However, this risk was not identified by the service and was not assessed promptly to demonstrate that risks had been managed, which failed to ensure that people were provided with safe care and treatment.

We reviewed the monthly weight records kept for two people. The weight records for one person showed minimal variation over the first seven months of the year up to an unspecified date in July 2015. There was then a significant drop in weight of 2.5kg on 15 August 2015. This was recorded on a scrap of paper tucked into the back of the person's care file. Body-Mass Index (BMI) calculations for the year indicated that this person was already underweight. There was no recorded evidence of action in response to the additional weight loss. For example, there was no contact noted on the 'Reviews and appointments' list for the person since the weight loss was recorded. Their monthly review dated 30 August 2015 did not refer to the weight loss or any actions taken in consequence. The person was weighed during our inspection visit and found to have lost a further 1.2kg of weight. Reasonable steps had not been taken to manage risks to this person's health and safety, which failed to ensure that they were provided with safe care and treatment.

We looked at the standard of individual risk assessments for people. Whilst they identified specific risks and stated brief actions to address them, they were not comprehensive nor kept up-to-date. For example, one person's risk assessments were reviewed on a monthly basis, with no change documented, up until 28 July 2015. They were involved in a safeguarding case earlier in July. However, despite the deputy explaining a protection plan for the person, their risk assessment had not been updated to recognise the allegation of abuse and how risks to the person's well-being were being reduced. Reasonable steps had not been taken to manage risks to people's health and safety, which failed to ensure that they were provided with safe care and treatment. It was also contrary to the service's Statement of Purpose which stated, "Risk assessments are undertaken for all new users and for existing service users whose circumstances may change."

Following our inspection, we were sent updated interim risk assessments for two people that were more comprehensive and included a range of actions in response to each risk. However, we were not confident that without our intervention, the service would have comprehensively reviewed people's individual risk assessments and taken action to minimise the risks.

There was evidence of oversight of medicines management in the service. A recent comprehensive medicines audit within the service had taken place. It identified that insufficient quantities of a liquid medicine were being supplied for one person, and we saw that action had been taken to rectify this. The supplying pharmacist had recently audited medicines at the service, and we could see that the small amount of recommendations arising from this were being attended to.

We saw people being supported to take medicines. Attention was paid to infection control processes, and ensuring that people consented to taking the medicines. The medicines administration record (MAR) was read and

checked against the medicines package. However, one person pointed out that the tablet they had been given was the wrong colour and so they handed it back. It was established that the medicine inside the package did not match the prescription label on the package, and had in fact been misplaced from another of the person's medicines that the service was looking after. The deputy started investigating what had occurred, for which we saw that staff statements had been collected before the end of our visit. However, if the person had not noticed their tablets to be incorrect, they would have been administered the wrong medicine. This was not proper and safe management of the person's medicines, which failed to ensure that they were provided with safe care and treatment.

When we checked through medicines in stock at the service, we found that the only discrepancy related to the above matter. The current supply of the particular medicine had run out, although the new stock due for starting the next day was instead used after the mistake had been discovered. There were no records explaining why the medicine had run out on the final day of the 28-day cycle. The MAR showed the medicine had been administered as prescribed across that period, except for one day when it was refused, for which the deputy showed us the refused tablet in separate storage. We also found one extra tablet of the medicine that was offered to the person in error. This meant there was a risk that the person had at some stage in the previous 28 days been administered the former medicine in error. This was not proper and safe management of the person's medicines, which failed to ensure that they were provided with safe care and treatment.

When we asked to see the medicines that one person had recently refused, we could only be shown one of the two sets in storage. The deputy could not explain where the other set was, as it was not in the designated place for refused medicines, nor were the tables in their original packaging. This compromised the effective audit and safe disposal of the tablets, which was not safe management of medicines.

Staff and people using the service told us that maintenance issues were quickly addressed. As one person put it, "It's up to scratch." There was some evidence of management of service-wide safety matters. We saw recent professional safety checks in respect of fire systems, gas appliances, and electrical wiring of the premises. There was a recent emergency plan in place that included plans for various business interruption scenarios along with missing persons procedures and contact details of relevant people in an emergency. We saw recent health and safety risk assessments for the premises and particular aspects of service management such as infection control. However, we saw ways in which premises and maintenance issues were not safely addressed, which put people at unnecessary risk of unsafe care and support.

From the start of the inspection, we heard an intermittent beeping sound in the kitchen. We established that it was coming from a smoke detector. A staff member told us that it had been like that only on the day of our visit, and that it needed batteries changing. We noted that it was not mentioned at the information handover for incoming morning staff, nor was it recorded in the maintenance book for action. The detector was still beeping at the time we left the service in the early evening, despite the service's maintenance worker visiting the service to attend to other matters during the afternoon. This failed to ensure that the premises and equipment was safe for use, which did not ensure that people were provided with safe care.

We looked at fire safety checks. Although there was evidence of new fire extinguishers, routine checks by the service were out of date. Records of smoke detector and emergency lights testing were last documented on 17 May 2015, a period of more than three months, although there had been almost-weekly checks throughout 2015 up until that point. The deputy told us that the allocated staff member had left the organisation, and that they had since found there to be no fire testing fob by which to activate the fire alarms. They showed evidence of purchasing a fob although it was not yet received in the service. We also saw that the emergency light in the downstairs hallway did not have its indicator working to show that it was operational. Checks of the emergency lighting would have identified this. This failed to ensure that the premises and equipment was safe for use, which did not ensure that people were provided with safe care.

As a result of our visit, the deputy informed us that a fire professional had been asked to visit to check fire equipment. The fire professional found that the emergency light was faulty, and replaced it. They also tested the fire alarm system to establish that it was working correctly.

Inadequate

Is the service safe?

The last documented fire drill at the service was on 10 May 2015. The shift allocation plan prompted staff to undertake a fire drill on Fridays; however, despite evidence of staff being recently allocated to do this, there was no record of undertaking the drill or documenting reasons why it did not occur. Reasonable steps had not been taken to manage risks to people's health and safety, which failed to ensure that they were provided with safe care.

The service's fire safety risk assessment dated 20 March 2015 was sent to us on request following the inspection as it could not be located during our visit. We noted that it incorrectly identified three people as using the service when there were four at the time of assessment, and that fire alarm testing would commence once the fob was acquired despite records showing fire alarm testing taking place weekly at the time of the assessment. The form used a scoring system to evaluate the overall risk. The system was not used correctly, as a number of low risks were identified, however, these added up to a risk beyond the maximum identified for high overall risk. There were no actions recorded as planned to reduce this overall risk. Reasonable steps had not been taken to manage risks to people's health and safety, which failed to ensure that they were provided with safe care.

We raised our fire safety concerns with the local fire authority, who consequently visited the service, but who were unable to provide feedback before this report was drafted.

The above evidence demonstrates a breach of regulation 12(1)(2)(a)(b)(d)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection of December 2014, the provider sent us an action plan in relation to recruitment shortfalls. It included that two references would be obtained before staff started work, and that all staff had supplied the required references. However, when we checked the recruitment files of the three most recently-employed staff members, we found insufficient evidence demonstrating good character because two of the staff members did not have appropriate references in place.

One staff member had a reference from a co-ordinator for their most recent care employment. However, there was no second reference in place, despite there being a letter to the referee and a handwritten note on it stating, "Follow up done." An audit at the front of the staff member's file, dated 31 January 2015, listed only one referee and had blank entries to the questions "Two references?" and "Any concerns?" Recruitment procedures had not been operated effectively to ensure that the staff member was of good character.

Another staff member had two references on file in advance of their employment. However, there was no official reference from the person's last care employer, instead a reference from someone who described themselves as a "colleague" and who was listed in the application form as "ex-deputy." The staff member had also declared working in a nursing home within the previous five years, however, no reference from that care employer was sought. We found no record documenting exploration of the one care employer reference on file being from an employer that was not declared on the staff member's employment history. There was no proof of identity or evidence of entitlement to work in the UK in the staff member's file. These were supplied to us during and after the inspection visit. Recruitment procedures had not been operated effectively to ensure that the staff member was of good character.

Two staff members' application forms made reference to working towards obtaining national vocational qualifications. One also noted a nursing qualification from abroad. There was no evidence in the files to confirm the qualifications or progression towards them. A copy of the nursing qualification was supplied to us after the inspection visit. Recruitment procedures had not been operated effectively to ensure that staff had the qualifications necessary for the work to be performed.

The above evidence demonstrates a breach of regulation 19(1)(a)(b)(2)(a)(3)(a) schedule 3 parts 4(a)(b) and 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supervision and induction records showed that staff understanding of abuse and safeguarding processes was checked. Staff we spoke with knew about different types of potential abuse of people and how to report any concerns in that respect. However, one staff member did not understand what whistle-blowing meant, and upon explanation, told us they did not recall being trained in that respect. The action plan in response to the breach of the safeguarding regulation at our inspection of December 2014 informed us that staff had signed the revised whistle-blowing policy to show that they had read and

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Is the service safe?

understood it, and that staff would be properly vetted including through references. We asked to see evidence of which staff had signed but this was not provided, and we found that appropriate staff references were not in place. Systems and processes to prevent abuse of people were not being effectively operated.

The above evidence demonstrates a breach of regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked staffing levels at the service and found that two staff worked across the day until 4pm, with one staff member working until 10pm at night and sleeping at the service. This staff member usually started at 5pm but was sometimes working from 9am. People using the service and staff had no concerns about staffing arrangements, however, a community professional raised concerns that as two staff had recently stopped working at the service, remaining staff were working long hours. We found that some staff were working up to 50 hours a week, with occasions of working from 9am one day until 4pm the next day. Only two staff were working the sleep-over shift. We asked the deputy and the director if there was a documented risk assessment for these arrangements. We were told there was none, but explained that this was short-term situation which staff were volunteering to help with, and which enabled a better consistency of staff. We were shown evidence that recruitment adverts had been placed. However, our overall findings from this inspection visit did not assure us that there were enough competent staff to ensure people received a safe service.

Inadequate

Is the service effective?

Our findings

At our previous inspection of 10 December 2014, we found that people were not always supported to maintain good health and address their health concerns. People were at risk of malnutrition as the service did not have procedures in place to monitor people's nutrition and support people to maintain a balanced diet. Staff had not received adequate supervision, appraisals and training, which put people at risk of receiving care that was inappropriate. This meant the provider was in breach of regulations 14, 23 and 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We were also not assured that the provider had ensured that staff had sufficient knowledge and understanding of the Mental Capacity Act 2005.

At this inspection, we found that there was insufficient evidence of improvement for these areas of concern. This was now breaches of regulations 9, 11, 12, 14 and 18 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service spoke positively about it. Their comments included, "It's good here" and "I give it ten out of ten." One community professional told us that the service had provided good outcomes for people; however, another raised concerns about the standard of services.

People told us of being happy with the food, for example, "Good meals, nice choice." People confirmed that meetings took place at which they decided what food was to be on the menu the following week, and that healthy eating was encouraged. However, a community professional told us of concerns about the variety of meal choices which they thought put people at risk of inadequate nutrition.

We saw that improvements had been made in the availability of fresh fruit and salad ingredients. Fresh apples, bananas, pears and grapes were provided in a fruit bowl on the kitchen table Raisins, cakes and biscuits were similarly available. A planned barbeque with salad took place at lunchtime, which two people using the service engaged in. The third person had a meal taken to them. There was enough food available to people, and staff provided people with support to cook meals.

A two-week menu cycle had been compiled by the deputy who, however, confirmed that they had no relevant nutrition training in respect of meeting the nutritional needs of people using the service. Whilst the menu provided evidence of people's choices, they lacked variety, and many of the dishes relied on pre-prepared or processed foods such as fish-fingers, nuggets, and Cornish pasties. A minority of dishes were being home-made from fresh ingredients. People's care delivery records rarely stated exactly what the person ate at meals, despite the deputy telling us that this was where it would be recorded. This did not demonstrate that people received suitable and nutritious food that was adequate to sustain good health, which failed to ensure that people's nutritional needs were met.

Records and feedback from the deputy clarified that nutritional advice from a qualified dietitian had not been sought. This was despite people having specific nutritional needs that were not being met. For example, records showed that one person needed to achieve and maintain a stable weight. However, there were no high calorie cakes or puddings available on the menu, which limited the person's energy intake and potentially impacted detrimentally on their weight and nutritional status. Records showed that the person's weight was decreasing and that there were records of the person being concerned about this. However, the documented responses included "continue supporting" without clarifying on the specific actions to be taken in response to the concerns. This support failed to meet the person's nutritional needs, as their most recent weight record before our visit showed a significant weight loss. A community professional informed us that a dietitian referral had been made for this person following our visit.

The care plan for another person included that they were to receive guidance to plan and develop healthy eating behaviours to assist with weight management. However, the menus we saw did not support this as there was little evidence of healthy eating options across the two weeks. The person's monthly reviews of care and support, dated June to August 2015, failed to consider nutritional needs, despite a documented weight gain in August. The previous week's care delivery records for this person did not contain reference to providing support with healthy eating. This support failed to meet the person's nutritional needs.

We noted that there were no formal assessments of nutritional risk in place for people despite identified nutritional needs. For example, there was no use of the Malnutrition Universal Screening Tool (MUST) that was

nationally available to assist with nutritional screening. People's nutritional risk factors were instead incorporated into one line or less of a generic risk assessment. For example, one person was not being weighed, and we understood from staff feedback and care records that they did not often leave the premises thereby having potential risks around vitamin D intake. However, these matters were not identified in their most risk assessment dated 22 May 2015 which had no other reference to nutritional risks. The service's approach to people's nutritional risks failed to meet their nutritional needs.

The above evidence demonstrates a breach of regulation 14(1)(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The bathroom scales available in the service were not sufficient to support one person to be weighed due to their physical disability. There was therefore no record of weight monitoring for this person. Despite our previous advice to the service about alternative means for monitoring the person's weight, and their care plan stating a need to maintain adequate dietary intake, the deputy could provide no evidence to demonstrate that the person's weight was being monitored. This failed to make reasonable adjustments to enable the person to receive care, and failed to have regard to the person's well-being in respect of nutritional needs.

The above evidence demonstrates a breach of regulation 9(1)(a)(b)(3)(h)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that staff were responsive if they felt ill, for example, in calling a GP and providing pain management medicine. A number of records we saw demonstrated this. For example, community professionals were contacted for advice after someone refused their medicines for two days, and following an incident that resulted in the police visiting the service.

A community professional praised the service's support with getting someone to attend healthcare appointments despite the person's reluctance. We saw records in support of this, including attempts for persuading professionals to visit people in the home. However, we also found some ineffective liaison with community professionals in support of people's health and wellbeing.

One person's recent keyworker records showed that their GP had encouraged healthy eating. We saw a subsequent request to the GP, dated 28 July 2015, for prescription of a nutritional supplement for the person on the advice of another community professional. We found that the supplement had not yet been prescribed. There was no evidence of following up on this request, to support the person's health and well-being, for example, in the staff communication book or in the person's care file. This was despite them being documented as underweight at the time of the request and then being recorded as losing further weight on 15 August 2015. This failed to ensure that, where responsibility for the person's care and treatment was shared with other healthcare professionals, timely care planning took place to ensure the person's health, safety and welfare.

There was a recent health professional record dated 28 July 2015 showing that one person was vitamin D deficient and a recommendation of incorporating a low-fat diet. A diet-sheet of suggestions was provided for this, which we found unused in the person's file. We found that the person's care plan had not been altered in response to the health professional advice. The appointment and outcomes were not referred to within the subsequent monthly review for the person dated 1 September 2015. We found no evidence within the previous week of the person's care delivery records of attempting to engage the person with health eating options or of low-fat foods being provided. The menu for the service had little evidence of low-fat options. This failed to ensure that, where responsibility for the person's care and treatment was shared with other professionals, timely care planning took place to ensure the person's health, safety and welfare.

The above evidence demonstrates a breach of regulation 12(1)(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A community professional told us of concerns with staff knowledge and skills in respect of supporting people effectively. We saw that staff had recently undertaken online training through a recognised care resource. Certificates included test scores, all of which demonstrated adequate understanding of the subject. The recent training included for medication, safeguarding, and food hygiene. However, none of the three staff files we looked at had any training on working with people who have mental health needs, despite this being a specialism of the service and people using it having these needs. Despite evidence of staff taking an online nutrition course, we found that staff

Is the service effective?

lacked sufficient skills and knowledge of the importance of nutrition and physical-health monitoring for the complex needs of people using the service, for example, in failing to provide one person with support with developing health eating behaviours and to document this process. This support and training was not appropriate to enable staff carry out their care and support duties.

A new staff member, who started working in the service in May 2015, told us they had a week-long induction before starting to work on the roster. However, they had not yet received a supervision meeting in support of their role. We found that two of the other three staff had no evidence of a formal qualification in care in their files, which was contrary to expectations within the service's Statement of Purpose. The induction record for one of these two staff members, from late 2014, was completed for only one of the four weeks. When we checked supervision records, we found that one staff member had received two supervisions in 2015, however, another had only one in place dated 9 February 2015. This was contrary to the plan we received in response to our inspection of December 2014, which stated that individual staff supervision meetings were occurring every three months. This support, supervision and training was not appropriate to enable staff to carry out their care and support duties.

The above evidence demonstrates a breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards. We saw that staff had undertaken online training on MCA, and that further training had been booked for MCA with the local authority.

The deputy told us that a formal application had been recently made to deprive a person using the service of their liberty in their best interests. We saw records indicating that the person had been assessed by relevant professionals, and so a decision on authorisation was imminent. This showed evidence of the service working in line with the provisions of the MCA. However, a risk assessment for the person sent to us following the inspection stated that there were concerns around the person's capacity to make a specific safety decision. A monthly review record dated 1 September 2015 for another person noted that they continued to refuse a referral to a dietitian. When we asked for evidence of any capacity assessments undertaken where people had been refusing care or treatment that might reasonably be seen as in their best interests, none was provided, including for the specific matters above. This failed to ensure that the provisions of the MCA were being followed in full.

The above evidence demonstrates a breach of regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

At our previous inspection of 10 December 2014, we found that staff did not always have the skills to communicate with people with different needs. We also saw some negative, disrespectful interactions between staff and people using the service. This meant the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we found that the approach and communication of staff towards people using the service was much improved. However, there was one instance which undermined the respectful treatment of people. This was now a breach of regulation 10 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about the approach of staff. "They're firm and fair," one person said, explaining that staff provided encouraging support for things like applying creams and getting a haircut. They said that there were occasional miscommunications, but that staff tried to understand. They added, "It's like a family home." Another person told us, "Staff are always helpful" and "They're very respectful."

There was, however, one instance where staff did not treat people in a caring manner. At the morning meeting between staff to handover information, a person using the service was present in the room with the three staff involved. The handover of information about this person's care and support included personal information, and did not involve the person. Staff talked about this person as if they were not present. This failed to treat the person with dignity and respect. Staff also talked about the care and support of other people using the service in the person's presence, which compromised the privacy of these other people.

The above evidence demonstrates a breach of regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were otherwise treated with dignity and respect. Staff spoke positively about people using the service, for example, that a person was "so helpful." Someone we spoke with told us of feeling appreciated by staff. We consistently heard staff knocking on people's doors and asking if they could enter rooms before doing so, and one person confirmed that this was always the case. People were asked for their verbal consent before being provided with care and support. When we arrived, the staff member present explained that they needed to attend to one person as they were supporting them with personal care, which demonstrated appropriate prioritisation.

A community professional commented positively on the approach of staff, explaining that they did not put pressure on people but engaged with them in a way that allowed trust to develop. For example, staff encouraged people to take on small tasks in the home and the community such as buying milk for the service. One person told us of being involved in household tasks in the service, and we saw this to occur. We also saw records confirming this, and that staff supported other people with skills development and autonomy for such thing as preparing meals. In this way, the service was ensuring that positive relationships were being developed with people using the service.

A staff member told us that, with the recent support of the deputy, there had been improvements in the way staff communicated with people using the service. They gave, as example, respecting people's support refusals but approaching them again after a short while if staff believed the suggested support was in the person's best interests. We saw positive, relaxed and caring interactions from staff towards people using the service who appeared comfortable with the approach of staff. For example, we saw one person choosing to eat with staff and other people using the service when they had been adverse to this at our previous inspection.

People told us they could come and go from the service as they pleased, but were asked to tell staff of where they were going and their expected time of return. We saw this to be the case, and that the people were not confined to the premises physically or by the approach of staff. They also confirmed that they had access to phones at the service.

People told us of being given options of being involved in their care planning. They did not report wanting more input in the process, one person saying, "It's under control." There was written evidence of some people's views being documented within their care plans, and of their involvement in signing plans and other documents such as records of looked-after money.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection of 10 December 2014, we found that people's care plans were not always up-to-date and accurately reflecting their needs. This meant the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we found that there was insufficient evidence of improvement for care planning. This was now a breach of regulation 9 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's care plans were not kept consistently up-to-date and accurate, which put people at risk of receiving care that was not responsive to their needs. For example, one person's plan was dated 30 April 2015. It did not include treatment advice from the person's GP on 28 July 2015 as a result the person experiencing pain. The plan stated instead, under "Physical Health", that the person's health was "manageable" and that they were "no longer getting pains." The person told us they had pain in their leg during our visit. Their 'review and appointments' list included GP appointments booked for the person complaining of pain on both 27 February 2015 and 06 May 2015. The person's risk assessment at the time of our visit was last reviewed on 29 July 2015, stating "None" to the amendments prompt. This was despite the risk assessment including "eating junk breakfast" and the recent GP advice including about a low fat diet that had not resulted in amendments to the person's care plan. At about 09:00 we saw the person eating a large bag of crisps. The three staff present in the room with the person did not engage with them to suggest an alternative. The care and support of this person about these health and nutrition matters failed to meet their need, including through falling to design care with a view to meeting those needs.

The maintenance book had an entry from 20 August 2015 about the shower not working in one person's room. It was fixed during our inspection visit, and the deputy informed us that the person had been using a shower in a vacant room in the meantime. However, the time taken, 13 days, to fix the issue was not prompt. The maintenance book showed that this was not the first fault with the shower. The deputy explained that the fault was something that staff could rectify as it was caused by the person mishandling the shower. However, this was not recognised in the person's current care plan and had not been effectively communicated to staff so that they could rectify the matter promptly. The care and support of this person about this matter failed to meet their needs, including through falling to design care with a view to meeting those needs.

Staff told us that one person could refuse care and support, and that there were recent changes to the way in which staff approached them if this occurred. However, we did not find recognition or guidance on this within the person's care plan or risk assessment except for the person refusing the sign the documents. This failed to design care with a view to meeting the person's needs.

People's care files had monthly reviews which included information on their goals and skills progress along with other key information on their care and well-being. However, the reviews did not monitor and evaluate all goals set up in people's care plans. For example, one person's goals on their care plan included achieving weight loss. However, whilst the monthly reviews provided some relevant information about the person's holistic progress, only the August 2015 review that was sent to us following our visit documented about the weight loss goal. The person's care plan included a specific exercise goal that staff were to document on a separate chart, however, the monthly reviews did not refer to this either. This failed to reassess the person's needs and preferences so as to monitor progress and redesign care as needed.

The provider's Statement of Purpose included that people using the service would be supported within the staffing arrangements to go on holiday. One person's goals progress included a summer holiday plan. This had been recorded as "ongoing" since the monthly review of January 2015. The July review stated that the person "is looking forward" to the holiday. Records of a meeting for people using the service date 23 July 2015 stated that two people were looking forward to a holiday, albeit there was no action for this recorded in the 'actions' section of the minutes. When we spoke with the person, they confirmed that they had not had the holiday and they were looking forward to it. However, we found nothing to indicate that action had been taken to organise the holiday. Following the inspection, we were sent the August monthly review for this person, which clarified that the holiday would no longer be taking place. Whilst we did see from monthly reviews that action was taken to support the person with other goals, this goal had not been addressed for eight months. They had also been scheduled since February

Requires improvement

Is the service responsive?

2015 to visit someone without evidence of the matter being addressed. The monthly reviews failed to document and take action to ensure that people received personalised care that was responsive to their needs and preferences.

One person's Key Worker Session record for 25 July 2015 was an exact replica of their 25 June 2015 session except for an update on a health matter. This did not assure of an effective key-working session that responded to the person's individual needs and views so as to provide them with opportunities to manage their care. .

When we spoke with one staff member, we found that they were not aware of a safety incident in respect of one of the people living in the service from five days before our inspection, nor of the outcomes of a health professional visit the previous day in respect of that person. The staff member was present at the staff handover meeting that morning. We knew of the incident as it was recorded about in the staff communication book; however, there were no staff signatures against it, to indicate that staff had read the message. The matter had not been recorded on the service's accident/incident forms, by which to help ensure that senior staff were made aware of the incident. This did not assure us of effective staff communication by which to help ensure that people received personalised care that was responsive to their needs.

The above evidence demonstrates a breach of regulation 9(1)(a)(b)(c)(3)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff supported them in the community if requested. We were told of recent trips to the London Eye and London Zoo along with attending a local church, which staff confirmed along with support for shopping and looking for voluntary work. A community professional confirmed that the person they worked with had established a number of community contacts through the service.

People spoke fondly of the weekly art therapist sessions provided within the service. The deputy told us this had been newly introduced, along with a weekly barbeque and regular coffee mornings at which staff and people using the service chatted informally.

We saw that the service had a complaints procedure. It was on display in the service's entrance hall. One person showed us their personal copy of the procedure. The procedure's details provided people with support avenues, and showed openness and a willingness to resolve matters. It included that verbal complaints would be responded to formally, which helped ensure the procedure's accessibility.

We saw that handling complaints was covered within the latest staff member's induction process. The staff member knew where to record complaints, and showed us that there had been no complaints documented since our last inspection.

The last documented meeting we found for people using the service was dated 30 July 2015. It included people's suggestions for improving the quality of the service they experienced, and information about planned changes to the service. People told us of regular meetings held about the service.

Inadequate

Is the service well-led?

Our findings

At our previous inspection of 10 December 2014, we found that people were put at risk because systems for monitoring quality were not effective. Important documents could not be found during the inspection, and records that were available were not always accurate or up-to-date. Additionally, although the provider had sought feedback from people about the quality of the food, the way this feedback had been obtained may not have allowed people to respond honestly. This meant the provider was in breach of regulations 10, 17 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, there was insufficient evidence of improvement for these areas of concern. This continued to fail to protect people using the service and staff against the risks of inappropriate or unsafe care. This was now a breach of regulation 17 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were also breaches of regulation 20A of the 2014 Regulations, as the service's rating was not on display in the service, and regulations 15 and 18 of the Care Quality Commission (Registration) Regulations 2009, as we had not been notified of a recent change of director for the registered provider and of recent incidents reported to or investigated by the police.

Community professionals gave mixed views on the management of the service. We were told of improved communication in recent months, however, that the service was not always well-led. There was feedback that the management team was open about recognising where improvements were needed, and that they took on board professional advice. However, our findings throughout this report were that many of our concerns from our previous inspection had not been acted on effectively and addressed. This was not effective governance of the service so as to identify and address risks to the health, safety and well-being of people using it.

Following our inspection of December 2014, the provider sent us an action plan in relation to governance shortfalls. It included that there were now audits for care plans, medicines, health and safety, buildings facilities and training. At his visit, we saw there to be some audits that senior staff undertook. These included weekly file checks for matters such as completion of handover sheets and the records of care and support provided to people. A monthly check documented that people's care files were audited. However, apart from the quarterly medicines audits that prompted for very specific checks, our evidence below demonstrates that these audits were not always effective at ensuring good governance of the service.

We saw records of weekly file audits up to 24 August 2015. These included a prompt for fire drills and fire checks, however, they were not signed off for that point, and there was no record of any concerns. As we found that fire drills and fire alarm checks had not taken place since May 2015, this was not effective auditing of fire safety check so as to assess, monitor and address any risks to the welfare of people using the service.

We checked care plan audit records in one person's file. Although undertaken by different staff members, the audits of 10 March 2015 and the most recent of 12 May 2015 had exactly the same information on them. These therefore did not demonstrate that the "action plan for improvement" was effective, and so the audit was not being effectively used to improve the quality of service to the person.

We found two incidents reported on in the service's accident/incident folder. Whilst these reported on immediate action taken by staff, the further actions sections about reporting to senior staff and appropriate agencies along with actions to prevent reoccurrence were left blank. The deputy confirmed that there was no system of incident analysis in use at the service. We found that the weekly files audits did include a prompt for the accident/ incident folder and that the most recent audit of 24 August 2015 did tick it as checked but with no action highlighted as needed, despite the two incident forms not being completed in full. We found details of an incident in the staff communication book from five days before our inspection visit; however, there was no accident/incident report of the matter. This was not effective auditing of incidents so as to assess, monitor and address any risks to the welfare of people using the service.

There was a first aid box easily accessible in the service. Weekly contents checks were made which established that from 7 August 2015, there was a small amount of further stock needed. The subsequent two checks showed that one item had been replenished but not the other three

Is the service well-led?

identified items. Records indicated that the check of 28 August 2015 did not occur. This was not effective auditing so as to assess, monitor and address risks to the welfare of people using the service.

We found there to be no tumble drier in the service. Whilst clothing could be dried on a washing line across many days during the summer, this was not a long-term solution. We saw a maintenance list dated 4 August 2015 identifying that a tumble drier was needed, and the deputy told us it had been requested from before that date. However, nothing was shown to us on request to demonstrate that action was being taken to purchase one, and the director told us he was not aware that the service did not have one. This was not effective auditing so as to improve the quality of services provided to people. We noted, however, that some aspects of the maintenance list had been addressed, for example, with ensuring that loose stairway carpeting had been made safe.

When we checked the laundry room, we found it was being used to store excess food and drink products such as water and squash bottles, and cornflakes packets. The laundry room had an offensive odour which the deputy explained was from the washing that was in the washing machine. The storage of the food items was not an appropriate infection control procedure, which demonstrated ineffective governance at the service.

The provider's action plan in response to our inspection of December 2014 included that food quality surveys were now being undertaken weekly by the manager or independent professionals. It also stated that six-monthly quality assurance surveys had been distributed to people using the service, families and staff, from which an action plan for improvements was produced. The process was to be repeated in July 2015. We found there to be weekly records of auditing people's views on the food provided, views from which were entirely positive, which matched people's feedback to us directly. However, the director and deputy confirmed that the last wider audit of people's views was in January 2015. The service's Statement of Purpose stated that these audits would take place quarterly. This was not effective auditing of people's overall views of the service, by which to assess, monitor and improve on the quality of services to people.

We saw that recent recruitment application forms and the staff induction workbook both had references to The Care Standards Act 2000. This Act was superseded in 2010 by The Health and Social Care Act 2008 and associated regulations. The induction process did not make reference to the Care Certificate standards that were introduced in April 2015. The provider's recruitment and induction documents were therefore out-of-date and not effectively reviewed for over four years. Effective auditing of these documents, so as to improve the quality of services provided to people, had not taken place.

We saw medication competency assessments for seven staff members. The manager had recorded six of these as taking place on one specific date in August 2014. We noted that recruitment records demonstrated that two of the staff members had not been working at the service until October 2014, meaning the date of assessment was inaccurate. The managing director confirmed that the assessment forms had not been in use until after our last inspection. This failed to demonstrate effective governance at the service.

One community professional told us of inconsistent record-keeping at the service, although another felt that improvements had been recently made. The deputy told us that the quality of records was not always sufficient, and hence training was being booked for all staff on record-keeping. Some of the records about people's care and support were appropriate. For example, records included about people's community presence, where someone had shopped on behalf of others, and where there had been visitors. However, we found examples of where the records kept about people's care and support were not accurate. For example, staff informed us that one person had needed specific support with their care on two different occasions during our visit. This support was not documented within the person's care delivery records provided to us after the inspection visit. The deputy told us one person was being supported to smoke in their room; however, the previous week's worth of care delivery records failed to refer to this support, and the support was not part of the person's care plan. These inaccurate records about people's care and support demonstrated ineffective governance at the service.

The care delivery record for one person stated that they had made breakfast with the support of staff on the day of our visit. However, at the staff handover meeting that morning, we heard that the person had refused breakfast and gone to eat at a local café. We saw that another person had enjoyed a barbeque with staff during our visit;

Is the service well-led?

however, their care delivery records did not mention the barbeque and stated that the person had eaten lunch in the lounge. Care delivery records sometimes referred to all tasks on the care plan being undertaken; however, this indicated that one person was, according to their care plan, attending a fitness trainer and going swimming regularly along with exercising in the service. Our discussions with the person and staff, and our observations, found no evidence that these activities occurred. These inaccurate and incomplete records about people's care and support demonstrated ineffective governance at the service.

The deputy told us that records of what people had eaten in the service were within daily care delivery records. However, when we looked at the previous week's records, these did not usually specify what exactly was eaten, just whether the person ate or not. Menus were kept, however, they were not complete records as they stipulated, for example, "pasta bake", "vegetables", and "sandwich" without clarifying the exact food provided. Dinner was always recorded as "Client's choice" without a record of which choice each person made. As people's care plans and health records indicated the need for support with a range of nutritional risks, the failure to document accurate and complete records of what people had eaten demonstrated ineffective governance in respect of assessing, monitoring and addressing risks to people's health, safety and welfare.

The staff communication book included a recent record of a community professional speaking with staff and a person using the service following an incident that resulted in the police visiting the service. However, this information was not documented within the 'reviews and appointments' list for the person, or in the monthly review of their care for that period. These inaccurate and incomplete records about the person's care and support demonstrated ineffective governance at the service.

Care delivery records for each person were kept unsecure within the conservatory. We also found incident records and minutes of an old safeguarding case being stored unsecure in this area. The deputy informed us that cabinets were on order in which to store these records securely, which showed that action was being taken long-term for security of people's information. However, at the time of our visit, insufficient action had been taken to keep these records secure in support of effective governance at the service.

The above evidence demonstrates a breach of Regulation 17(1)(2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, we became aware that the police visited the service in response to a matter reported to them on 10 August 2015. They had also visited the service later in August, on a separate safeguarding matter. Neither matter had been notified to us as required by legislation. We were not aware of the former incident until we saw a record of it during our visit. We also found that there had been a recent change of directors in the provider organisation, and so the nominated individual on behalf of the provider company was no longer in a position of authority with the company. We reminded the director about notifying us of this change; however, that had not occurred by the time of drafting this report. The failures to promptly notify us of these matters did not demonstrate a well-led service.

The above evidence demonstrates breaches of Regulations 15(1)(e)(ii) and 18(1)(2)(e)(f) of the Care Quality Commission (Registration) Regulations 2009.

During our visit, there was no display of our current rating of the service's performance, or copy of the last inspection report, available in the hallway where other information was displayed, or anywhere else prominent in the service. Since April 2015, it has been a legal requirement to display our rating in a conspicuous place within care services. The director and the deputy told us it had fallen off. However, it had not been replaced.

The above evidence demonstrates a breach of Regulation 20A(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy told us of recent work with the local authority's Quality in Care Homes team. A memo to the provider documented a set of recommendations arising from this for medicines and records security. We saw evidence of action being taken arising from this, for example, the purchase of a digital thermometer for medicines temperature checks, and the director was aware of other requests.

One person told us of there being "teamwork" between people using the service and staff. Another person told us they knew the maintenance worker was visiting later today. It was evident that people were kept informed and involved with aspects of how the service operated, indicating an open and inclusive culture.

Inadequate

Is the service well-led?

Staff told us there was always a manager available to phone if support was needed at any time. We saw records of regular staff meetings taking place at the service. These included guidance to staff on care delivery expectations and other standards for the service including cleaning, medicines management and record-keeping. There was opportunity for staff to raise and discuss concerns. This information helped to demonstrate a positive, inclusive and empowering culture at the service.

The service did not have a registered manager, although the manager had applied for registration. The manager informed us of going on leave mid-July for three weeks, however, they did not return to the service from the leave until the day before our inspection, and were not present at the inspection visit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person failed to ensure that care and treatment of service users was appropriate, met their needs and reflected their preferences. In particular, this included failure to:** • carry out an assessment of the needs and preferences for care and treatment of the service user; • design care or treatment with a view to achieving the service user's preferences and ensuring their needs are met; • provide opportunities for relevant persons to manage the service user's care or treatment; • make reasonable adjustments to enable the service user to receive their care or treatment; • have regard to the service user's well-being where meeting their nutritional needs. **Regulation 9(1)(a)(b)(c)(3)(a)(b)(e)(h)(i)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person failed to ensure that service users were treated with dignity and respect and that their privacy was ensured.** **Regulation 10(1)(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

The registered person failed to act in accordance with the Mental Capacity Act 2005 Act where service users were unable to give such consent to care and treatment because they lacked capacity to do so.

Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. In particular, this included failure to: • assess the risks to the health and safety of service users of receiving the care or treatment; • do all that is reasonably practicable to mitigate any such risks; • ensure that the premises is safe to use and is used in a safe way; • ensure that the equipment is safe to use and is used in a safe way; • properly and safely manage medicines; • where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, • work with community professionals involved in the care and treatment of service users to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. Regulation 12(1)(2)(a)(b)(d)(e)(g)(i)

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 Systems and processes were not operated effectively to prevent abuse of service users. Regulation 13(2)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes were not established and operated effectively to ensure compliance with the relevant regulations. In particular, this included failure to effectively operate systems to:** • assess, monitor and improve the quality and safety of the services; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; • maintain securely an accurate and complete record in respect of each service user; • seek and act on feedback from relevant persons and other persons on the services provided, for the purposes of continually evaluating and improving such services; • evaluate and improve practices in respect of the processing of the information referred to above. **Regulation 17(1)(2)(a)(b)(c)(e)(f)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The support, supervision and training of staff was not appropriate to enable them carry out the work they were to perform.** **Regulation 18(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures were not operated effectively to ensure that staff were of good character and had the qualifications necessary for the work they were to perform.** **Regulation 19(1)(a)(b)(2)(a)(3)(a) schedule 3 parts 4(a)(b) and 6**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **There was no display at the premises of a sign showing the most recent rating by the Commission that relates to the service provider's performance at those premises.** Regulation 20A(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes **The registered person did not give notice in writing to the Commission, as soon as was reasonably practicable to do so, of a change of director.** Regulation 15(1)(e)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person did not notify the Commission without delay of the following incidents which occurred whilst services are being provided in the carrying on, or as a consequence of the carrying on, of a regulated activity:** • any abuse or allegation of abuse in relation to a service user; • any incident which is reported to, or investigated by, the police. Regulation 18(1)(2)(e)(f)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person failed to ensure that the nutritional needs of service users, including receipt of suitable and nutritious food which is adequate to sustain life and good health, were met. Regulation 14(1)(4)(a)

The enforcement action we took:
We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activity that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 18 December 2015.