B&H Care Ltd

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Inspection report

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Date of inspection visit:
01 November 2016
02 November 2016

Date of publication:
28 December 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We completed an unannounced inspection at B&H Care Ltd on 1 to 3 November 2016. This was the first inspection since the service was registered with us in December 2013.

We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration Requirements) Regulations 2009. The overall rating for this service was 'Inadequate' and the service was therefore immediately placed in 'Special measures'.

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

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service is registered to provide personal to people in their own homes. At the time of our inspection six people were using the service.

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

At this inspection, we found that the registered manager and provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the registered manager or provider.

Risks to people's health, safety and wellbeing were not identified, managed and reviewed and medicines

were not managed safely.

People were not protected from the risk of abuse because suspected abuse was not reported as required.

Safe recruitment systems were not in place, so people could not be assured that the staff were suitable to support them in their own homes.

Staff were not effectively deployed, so care calls were frequently late which impacted on people's health and wellbeing.

People did not always receive their care in line with their care preferences and their care needs were not regularly reviewed. People's care plans were not accurate and up to date which meant staff didn't always have the information they needed to provide safe and consistent care.

Staff did not have the knowledge and skills required to meet people's individual care needs and keep people safe. People's health was not effectively monitored and managed to promote their health and wellbeing.

People were not always treated with dignity and their rights to make choices about their care were not always respected. People told us they sometimes received care they had not consented to.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure people decisions about care were being made in people's best interests when they were unable to make these decisions for themselves.

Effective systems were not in place to ensure concerns about the quality of care were recorded, investigated and managed to improve people's care experiences.

The registered manager and provider were in breach of the conditions of their registration with us as they were operating the service from an unregistered location. The registered manager and provider did not notify us of reportable incidents and events as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not protected from the risk of abuse as suspected abuse was not reported as required. Systems were not in place to ensure staff were suitable to work with vulnerable people in their own homes.

Staff were not deployed effectively to ensure people received the care and support they needed at the agreed time.

Risks to people's health and wellbeing were not identified, managed and reviewed. Medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective. Staff did not have the knowledge and skills needed to keep people safe and meet people's needs effectively.

People's health needs were not effectively identified, monitored and managed to promote their health, safety and wellbeing.

The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were made in people's best interests when they could not make decisions for themselves.

People were at risk of dehydration and malnutrition as they did not always receive the support they needed to eat and drink at the agreed times.

Is the service caring?

Inadequate

The service was not caring. People were not always treated with kindness and dignity and people's right to makes choices about their care was not always respected.

The service was not operated in a manner that promoted a caring environment for the people who used the service and the staff.

Is the service responsive?

Inadequate

The service was not responsive. An effective complaints system was not in place to respond to people's concerns regarding the quality of care.

Reviews of people's care needs were not completed effectively. Care records were not accurate or up to date, therefore the information staff needed to meet people's individual care needs and preferences was not recorded.

Is the service well-led?

Inadequate

The service was not well led. Effective systems were not in place to protect people and staff from risks to their health, safety and wellbeing.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

The registered manager and provider were in breach of the conditions of their registration with us as they were operating the service from an unregistered location. The registered manager and provider did not notify us of reportable incidents and events that occurred at the service.

B&H Care Ltd

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 was 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.

We undertook an unannounced inspection of B&H Care Ltd on 1 to 3 November 2016. This inspection was completed in response to concerns that had been shared with us about the safety and quality of care. These concerns had been raised by people who used the service and the local authority. We inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well-led? Our inspection team consisted of two inspectors.

We checked the information we held about the service and provider. This included the information we had received from the public and local authority. We used this information to formulate our inspection plan.

We spoke with five people who used the service, five relatives, five members of care staff, the registered manager (who was also the provider) and the care manager (who was also the provider) . We also spoke with two health and social care professionals who visited people who used the service. We did this to gain people's views about the care and to check that standards of care were being met.

With their consent, we visited people who used the service in their own homes and observed how the staff interacted with them in. We looked at the care records of the five people we visited to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files and rotas.

Following our inspection we shared our findings and concerns with the local authority. We did this because we identified that people were at risk of immediate harm to their health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

Three of the five people we spoke with told us they did not feel safe receiving care from the registered manager. One person told us and their care records showed that the registered manager continued to visit them at their home despite informing them that they did not want to receive care from them. This person told us they felt unsafe and had changed the code to their key safe to prevent the registered manager from entering their home. This meant half the people who used the service did not feel safe receiving care from the registered manager.

Staff made us aware of three recent incidents of alleged abuse. These incidents had all been reported to staff by people who used the service and all three incidents were also witnessed by staff members. Staff told us all three incidents were reported to the care manager. However, the care manager confirmed they had not reported these incidents to the local safeguarding team in accordance with local and national guidance. We asked the care manager why the most recent allegation had not been reported to the local safeguarding team. They said, "I only found out about it last week". Local and national safeguarding guidance states that incidents of alleged abuse should be immediately reported in order to safeguard people from further potential abuse. This showed that the care manager did not follow safeguarding procedures to report incidents of alleged abuse. Therefore people who used the service were not protected from experiencing further safety incidents as incidents were not reported as required.

We asked the registered manager if the service had a safeguarding policy/procedure in place. They confirmed that a policy was not in place, but told us they were working on developing one. This meant there was no safeguarding guidance available for staff to follow to ensure safeguarding concerns were reported to protect people from the risk of abuse.

The above evidence shows that effective systems were not in place to protect people from the risk of abuse and avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of immediate and continued harm as a result of this Regulatory breach.

People were also not protected from the risk of abuse and avoidable harm because systems were not in place to ensure staff were of suitable character to work with vulnerable people in their own homes. It is important that providers can show that staff who visit vulnerable people in their own homes are of suitable character to do so. This is to ensure that people are protected from the risk of potential abuse or harm from the staff. The registered manager gave us a list of six care staff who provided care and support. However staff records were only available for two of these six staff. This meant no information was available for four of the care staff to show their employment history, their identification/ right to work and their suitability to work with vulnerable people in their own homes. Out of the two staff files that were available to view only one contained evidence that the appropriate checks had been completed to show the staff member was suitable to work with vulnerable people. Three of the staff we spoke with confirmed they had not been asked to give employment referees before or during their employment at the service and all three confirmed a disclosure and barring check (a check of a person's criminal records) had not been completed. This meant

people could not be assured that the staff who supported them were safely recruited. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of immediate and continued harm as a result of this Regulatory breach.

People told us and records showed that they did not always receive their care at the agreed time. One person said, "Sometimes the girls are late and they don't always let us know". A relative told us they had recently had to phone another family member to prepare food for their relation who was hungry because the care staff had not visited at the agreed time. The staff rota showed that this person's care call was due at 16:35pm. However staff told us that on the day the above incident occurred, they did not visit the person until 18:33pm. This meant this person waited just under two hour's for the support they needed. This person also told us they declined their pain medicines at the 18:33pm call as the care staff were next due to visit at 20:30pm and they were worried it would be unsafe to take their pain medicines again so soon. This meant the person could not take their medicines as prescribed and they experienced pain as a result.

The staff rota for the week of our inspection recorded 'do best' for two people's night time calls rather than recording the time that these people should receive their care. Care records for one of these two people showed that in the three days leading up to our inspection, the time they received their night time care call varied from 21:17pm to 23:34pm. This person told us, "My bed time varies, it's not always happening right". This meant the person had experienced a significant variation in the times they received support from the staff to get ready for bed.

Staff told us they were unable to visit people at their agreed times. One staff member said, "There's not enough staff. It puts extra pressure on is and makes us late for care calls. The registered manager knows about it, but nothing's been done". Another staff member said, "It's stressful for us and care can be a bit late". There was no effective system in place to enable the registered manager to identify if people were receiving their care at the agreed time. As a result of this, the registered manager was unable to assure us that they were taking action to ensure there were enough staff to ensure people received care and support when they needed it.

The above evidence shows that effective systems were not in place to ensure there were enough staff available to keep people safe and meet people's care needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health, safety and wellbeing were not effectively assessed, managed and reviewed. For example the registered manger told us one person was at risk of; falling, malnutrition, dehydration, skin damage and wound infections. None of these risks were assessed and planned for in the person's care records. Care records showed and a visiting health care professional confirmed that this person's skin was becoming increasingly damaged. We asked the staff how they managed this person's risk of skin damage and each staff member gave us a different account of the care they provided for this person. Because there were no plans in place for staff to follow and staff had been managing this risk differently, we could not be assured that the person's recent skin damage had not been caused by this inconsistent and unplanned care.

We saw that the information contained in people's care records was inaccurate and not up to date. For example, one person's care records had not been updated to show they now needed staff to use a hoist to move them safely. The staff we spoke with were aware that this person's needs had changed, but any new or temporary staff would not have access to this important information. This meant there was a risk that people would receive unsafe care and support because their care records were not accurate and up to date.

We found that systems were not in place to ensure people's medicines were managed safely. One person was prescribed a potentially lifesaving 'as required' medicine to help them to breathe. There was no guidance for staff to follow to enable them to identify when they would administer this medicine and staff also gave us different accounts of when they would administer the medicine. This meant there was a risk this person would not receive their medicine when they needed it. Another person was prescribed a number of 'as required' creams for their skin. Again, no guidance was available for staff to follow and again staff told us they were applying these creams at different frequencies. This person's skin had recently deteriorated and we could not be assured that this deterioration was contributed by them not receiving their creams as prescribed.

The above evidence demonstrates that effective systems were not in place to ensure people received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of immediate and continued harm as a result of this Regulatory breach.

Inadequate

Is the service effective?

Our findings

Staff did not have the knowledge and skills to meet people's needs effectively and safely. One staff member told us how they had recently struggled to use the hoist to support a person to move safely. They told us they had needed to call the care manager out to show them how to use the hoist, but they had continued to struggle to use the hoist again when they next visited the person. This staff member told us they had received no training from B&H Care Ltd.

We asked four members of care staff if they had completed safeguarding training. All four staff told us they had not completed this training. This meant staff had not received training to enable them to identify and report incidents of abuse. This meant staff were unaware of their individual responsibilities to ensure people were protected from the risk of abuse. We saw that incidents of alleged abuse were not being reported correctly as a result of this knowledge and skills gap.

The registered manager told us staff did receive some training in moving and positioning and medicines management, but training records were not available for us to view to confirm this and some staff told us they had not received this training. The registered manager confirmed that there was no training schedule in place to show what training was needed and when it was completed and due for renewal.

The above evidence shows that staff did not have the knowledge and skills they needed to ensure people's safety and wellbeing and service users were at risk of immediate and continued harm because of this. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of immediate and continued harm as a result of this Regulatory breach.

People's health needs were not effectively identified, monitored and managed to promote their health, safety and wellbeing. One person's relative told us their relation who used the service had a significant medical condition. This condition required close monitoring to promote the person's health and wellbeing. Only two of the five care staff we spoke with who provided care and support to this person were aware of their medical condition. This meant there was a risk that potential changes in this person's health would not be identified and acted upon as staff did not know what signs and symptoms to look out for to promote the person's health, safety and wellbeing.

Two of the people's care records showed they needed to have their urine output monitored by the staff. However no guidance was available for the staff to follow to identify if people's urine output was within an acceptable range. None of the staff we spoke with about this knew people's acceptable ranges or when they should report a concern. This meant these people's health needs were not being monitored and managed effectively to promote their health, safety and wellbeing.

Information was not contained in people's care records to show that advice from health professionals had been sought and acted upon to ensure people's health needs were met. For example, advice had not been sought from a health professional to enable the staff to formulate a plan of care to ensure one person's high

risk of skin damage was planned for. This person's health care professional confirmed that the staff reported changes in the person's skin to them, but they had not been approached to ensure a suitable plan of care was in place to prevent skin damage from occurring.

The above evidence shows that effective systems were not in place to ensure people were supported to maintain their health and wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of immediate and continued harm as a result of this Regulatory breach.

Most people told us the staff gained their consent before they supported them. However, we found that people's right to refuse care was not always respected. For example, when one person did not consent to the registered manager visiting them at home they told us and their care records showed that the registered manager continued to visit. This person told us they had not agreed for the registered manager to continue visiting and this had continued to happen without their consent. This showed that this person had received support that they had not consented to.

The care manager told us that one person who used the service was sometimes unable to consent to their care because of their medical condition. We found that the requirements of the Mental Capacity Act 2005 (MCA) were not being followed to ensure this person received care that was suitable and in their best interests. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. No record of this person's capacity to make decisions about their care had been completed by the registered manager or provider as required in accordance with the MCA. All the staff we spoke with told us they had not received training in the MCA so they were not equipped with the knowledge and skills to follow the legal requirements of the Act. This meant we could not be assured that this person had received suitable care in their best interests as the MCA had not been followed.

The above evidence shows that systems were not in place to ensure care was provided in accordance with people's consent and when people were unable to consent the requirements of the MCA were not followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were supported to eat and drink. However, people told us they were not always supported to eat and drink when they were hungry and thirsty because the staff did not always visit on time. One person's relative told us their relation's appetite had decreased and their desire to eat reduced after prolonged periods of hunger. This meant it was important for this person to receive their care and support on time so their eating and drinking needs could be consistently met. This person told us and staff confirmed they did not always receive their care at their agreed time. This meant this person and other people were at risk of dehydration and malnutrition.

Inadequate

Is the service caring?

Our findings

All five people told us that the female care staff that visited them were kind and caring. One person said, "The girls are nice". A relative told us how staff had completed extra tasks that were not care planned for to help ease their role as a family carer. However, four of the five people we spoke with told us the registered manager did not treat them with dignity and respect. Comments from people included, "He talks across me", "Not very friendly" and "Funny attitude". Staff also confirmed that the registered manager did not always act in a kind and caring manner. One staff member said the registered manager had been, "Rude to [a person who used the service], abrupt and talked down to them". They told us this made them feel, "Uneasy" as a staff member. Another staff member told us how they had needed to apologise to a person after they witnessed the registered manager using inappropriate verbal and body language towards a person who used the service. This showed that people were not consistently treated with dignity and respect when they received their care.

Peoples care records showed undignified language was occasionally used by the staff. For example in one person's care records we saw staff had recorded the person was in a 'right mood'. Another person's records stated they were in a 'mood again'. The use of this language showed that staff had very little understanding about the behaviours people presented with. There was also a risk that changes in people's mental health and wellbeing would not be identified if staff interpreted people's behaviours and presentation as 'moods'.

People told us the choices they made about their care were not always respected by the registered manager. For example, one person told us that the registered manger had on a number of occasions challenged and questioned a lifestyle decision they had made. This person had full capacity to make decisions about their care and their right to make this decision was not respected by the registered manager. A visiting health and social care professional also confirmed that this person's right to make choices about their care was not being respected by the registered manager.

The above evidence shows that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us the service was not operated in a caring manner to promote a caring environment. One person told us, "He [the registered manager] makes [the care manager] cry all the time". Staff described the registered manager as, "Hot headed" and "Unpredictable". One staff member told us that an emergency meeting to discuss concerns they had raised about late care calls and staff rotas was held by the care manager in a person who used the service's kitchen. This was not an appropriate place to hold a meeting about the concerns the staff member had raised as it did not respect this person's right to privacy in their own home.

The registered manager and provider did not have systems in place to ensure people were treated in a caring manner. Care calls were frequently late which impacted on people's health, safety and wellbeing, but no action was being taken to address this care concern.

Inadequate

Is the service responsive?

Our findings

People told us that their complaints about their care were not managed to their satisfaction. One person told us they had complained about the registered manager and had felt intimidated by them when they visited them without a family member present to talk about the complaint. This had left the person feeling unsafe and worried about their safety. There was no system in place to ensure that any complaints that were made about the registered manager were investigated by another person, such as the care manager/provider. This meant that complaints about the registered manager were being investigated by him which meant people could not be assured their concerns and complaints would be investigated and managed fairly and independently.

Another person told us they had made a complaint about the way the registered manager supported them. They told us they had not received any information showing how their complaint had been dealt with and were unaware of any outcome to their complaint.

We asked the registered manager for written evidence to show how complaints were recorded and managed, but no complaints records were kept or maintained to show this.

The above evidence shows that people's complaints and concerns were not managed effectively to promote their health, safety and wellbeing. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the registered manager and provider were not responsive or respectful of the wishes of the people who used the service. Two people told us that they had complained to the staff and registered manager about the registered manager's behaviour and had requested that he didn't visit them at home again. Both people told us that despite raising this complaint, the registered manager continued to visit them at home. One person's records confirmed that the registered manager had visited them on at least a further eight occasions against their will. This showed people's wishes about which staff supported them were not respected.

Another person told us how they liked to be supported to wash. They told us the registered manager had visited them at home and told them to wash in a way that did not meet their care preferences. This upset the person and left them dissatisfied with their care.

People also told us that they did not always receive their care at the agreed time. This meant that people's needs were not always met in line with their personal care preferences. For example, because of late care calls, people were not always supported to eat and drink when they were hungry or thirsty.

People told us they had not been involved in a review of their care needs to ensure the care they received was in line with their care preferences. The information contained in people's care records was not accurate or up to date. This resulted in people receiving inconsistent and unsafe care from the staff. For example, one person's creams were applied by staff differently which may have led to the recent deterioration of the

person's skin. There was also a risk that any new or temporary staff would not be able to meet people's care needs safely as people's care plans did not contain the essential information needed to keep people safe. For example, one person's care records did not record the person's significant medical condition and another person's care records did not record how they should be supported to move safely.

The above evidence shows that people did not receive care that met their personal care preferences and care needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

On our arrival at the office, we asked the registered manager to provide us with a list of the people who were receiving care and support. No list was kept or maintained at the office and the registered manager and the administration assistant had to brainstorm and handwrite the list of the six people who used the service. They could not recall the surname of one of these people. This meant we could not immediately identify who was in receipt of care. This also meant this list was not readily available in the event of any potential service disruption which meant there was a risk people's care calls would not be covered in the event of service disruption.

The addresses of the people who used the service were not available at the office. This meant that in the event of an emergency situation effecting people or staff, people's addresses could not be shared with emergency services if required. This placed people and staff at immediate and continued risk of harm to their health, safety and wellbeing.

People's addresses were given to us by the administration assistant who had this information stored at their own home address. This meant confidential information about people who used the service was being stored away from the office. We could not be assured that this confidential information was being stored securely as required. This meant there was a risk that people's confidential information could be accessed and used inappropriately, placing people at risk of harm.

We also asked the registered manager to provide us with a list of the staff who were employed to provide care to people. No accurate staff list was stored or maintained at the office. This meant we could not identify which staff were providing care to people. We could also not be assured of the staffs' suitability to work with vulnerable people as staff records were not maintained. This placed people at immediate and continued risk of harm to their health, safety and wellbeing.

We asked the registered manager for a copy of the current staff rota so we could see who was in receipt of care, when they were receiving it and who was delivering the care. A copy of the staff rota was not available at the office. The administration assistant fetched this from his own home address for us. This meant that the registered manager and provider did not know who was receiving care, when they were receiving it and who by. This meant if a staff member suddenly became unavailable the registered manager would not be able to arrange cover to ensure service user safety was maintained. This placed people at immediate and continued risk of harm to their health, safety and wellbeing.

There were no effective systems in place to ensure the quality of care was regularly assessed and monitored so that improvements to care could be made. The registered manager confirmed that no systems were in place to ensure people's care records were accurate and up to date. People's completed care records were not always returned to the office to check that people had received the care they had agreed to. This meant the registered manager and provider had not reviewed whether the information contained in people's care records was accurate and up to date. They had also not identified that the written language used by some care staff within the care records was inappropriate.

Staff and the registered manager confirmed that no competency observations had been completed to ensure staff were carrying out their role effectively and safely. Staff and the registered manager also told us that no system was in place to assess, monitor and manage the staffs' development needs through an appraisal and supervision system. This meant the training and development needs of the staff had not been identified and met.

There was no system in place to identify if late or missed calls were occurring. People and staff told us and care records showed that some people were waiting over two hours for their agreed care call. The registered manager and provider were unaware of these late calls which meant improvements to people's care could not be made.

We found that the registered manager had not gained feedback from people about their experiences of the care provided. People told us they had not been asked for feedback and when they had raised any concerns verbally these concerns had not been listened to or acted on by the registered manager. The registered manager confirmed that no satisfaction questionnaires were sent to people who used the service to gain feedback about the care. This meant people's feedback was not sought and used to improve the quality of care.

The above evidence shows that effective systems were not in place to assess, monitor and improve the quality of the service provided. Systems were also not in place to identify and manage safety risks and to ensure people received safe, effective, responsive and appropriate care. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service had not been managed from its registered address for a period of over two years. The registered manager and provider had not notified us of their change of address. The registered manager told us they knew they should have notified us of this change but had not got round to sending the relevant notification form to us. This meant the registered manager and provider were in breach of their registration conditions. This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

During the inspection, we were made aware of three incidents of alleged abuse. None of these incidents had been reported to us as required under our registration Regulations. This meant we did not have access to the information that enables us to effectively monitor the safety of the service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.