Sunrise Mental Health Ltd

Fairlawn

Inspection report

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London
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 3 and 9 May 2018. This was the first inspection of the service since it was registered in May 2017.

Fairlawn is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Fairlawn is registered to accommodate five adults with mental health care needs. At the time of the inspection the care home was providing personal care and accommodation for four people and there was one vacancy.

A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager is the director of the organisation that owns Fairlawn and was present on both days of the inspection.

We observed that people who used the service were at ease with the care staff and the management team. Staff told us that they enjoyed working at the service and felt supported by the provider.

Risks to people's safety, health and wellbeing were not always identified and managed in an effective and positive manner. Staff did not consistently have appropriate written guidance within people's care plans and accompanying risk assessments in order to demonstrate how they managed behaviours that challenged the service.

People stated that they felt safe using the service and thought that staff knew how to protect them from the risk of harm and abuse. The relatives we spoke with thought that staff were caring and committed to keeping their family members as safe as possible. However the provider had not appropriately informed us of events at the service that impacted on people's safety, which meant we did not have accurate information in order to monitor the safety of people who used the service.

People received support from staff to receive their medicines. Staff had received applicable training and daily checks were carried out in order to minimise the risk of medicine errors occurring. The provider needed to ensure that potential risks were comprehensively assessed in circumstances where people progressed to managing aspects of their own medicine regime.

Staff were provided with training, support and supervision to enable them to meet the needs of people who used the service. The staff we spoke with told us that they had received induction training and opportunities to shadow experienced staff when they commenced employment with the provider, which was followed by a mandatory training programme. The training to meet the specific mental and physical health needs of people living at Fairlawn was limited in scope.

People who used the service were encouraged to make choices about their food and drink, however the provider did not demonstrate that people engaged in healthy grocery shopping and cooking.

Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported by staff to access health care services and attend health care appointments.

People and their relatives told us staff were compassionate and kind. We saw positive interactions between people who used the service and staff during the inspection. People told us that they were treated in a respectful way, and their privacy and independence were promoted. However we noted practices that did not protect people's confidentiality and may have impacted on their wellbeing.

Systems were in place to support people to avail local leisure and social resources and take part in activities at home and in the wider community, although some people did not have their requested leisure and social wishes met.

People and their relatives were informed about their entitlement to make a complaint. Relatives reported that they thought that any complaints would be investigated by the provider in an open and responsive manner.

People and relatives were happy with how the service was managed. There were quality assurance systems in place to gather the views of people living at the care home and monitor the quality of the service provided. However, the provider's own audits had not picked up on issues we identified during the inspection.

We have recommended that the provider seeks advice in relation to the support needed for people who self-administer medicine. We found two breaches of regulations in relation to the provider ensuring that robust risk assessment are in place, and the appropriate authorities are informed about safeguarding events and visits to the service by the police. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although staff understood how to protect people from the risk of abuse and harm, the provider did not appropriately inform the CQC to enable us to effectively monitor people's safety.

There were risk assessments to identify and mitigate risks to people's safety, however some of the risk assessments lacked sufficient information to satisfactorily guide staff and adequately promote people's safety.

People were supported by sufficient staff, who were safely recruited.

Appropriate systems were in place to support people with their prescribed medicines. However, the provider needed to ensure that risks were assessed where people managed all or aspects of their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received guidance and training to meet people's needs, however the training and development programme was limited in relation to courses that focused on people's mental health and physical health care needs.

People were supported to gain skills and confidence with grocery shopping and cooking. Systems were in place for people to receive advice and support from staff about healthy eating, although this was not reflected in terms of the nutritional quality of food available in the main kitchen.

People were supported to attend health care appointments and meet their health care needs.

Staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and they sought people's consent to care and support.

Is the service caring?

Good

The service was caring.

People and relatives told us that staff were kind and caring.

Staff supported people to make their own choices and increase their independence.

Care and support was delivered in a way that promoted people's entitlement to dignity and privacy, although we identified issues that needed to be addressed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed prior to admission and they were encouraged to take part in the care planning process.

Care and support plans did not have sufficient detail about how people's needs were met.

People and their representatives were informed about how to make a complaint and the process for complaints investigations by the provider.

Is the service well-led?

Requires Improvement

People and their representatives told us that the registered manager was supportive and involved in their care.

Staff expressed that the management team had an open approach and supported their development.

The provider's quality monitoring systems did not always identify issues for improvement.

The systems for reporting events in line with legislation was not sufficiently robust.

Fairlawn

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 3 and 9 May 2018 and was unannounced on the first day. We advised the provider of our intention to return on the second day. The inspection team consisted of an inspector and an inspection manager on the first day, and the inspector concluded the inspection on the second day.

Prior to the inspection we reviewed the information the Care Quality Commission held about the service. This included notifications sent by to us by the provider and any information received from other sources. The provider completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted two local authority commissioners and the safeguarding leads for the local social services and mental health trust.

During the inspection we were introduced to the four people who used the service and had discussions with two of the people. We also spoke with one support worker, the recovery manager (the home manager), the registered manager and the operational manager. We looked at a range of documents which included two people's care and support plans, four staff recruitment, supervision and training records, selected policies and procedures, medicine administration records and audits undertaken as part of the provider's quality assurance processes.

Following the inspection we spoke with the relatives of two people who used the service and contacted two health and social care professionals with experience and knowledge about the service. We received one written response.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe and happy living at their home. Comments included, "I like it here, it's been fine" and "I love it… there was no positivity in my life before." One relative told us, "It feels safe here. I see staff look after people as if they were their own blood relatives" and the relative of a second person stated that the service had provided a stable and reassuring environment for their family member.

The provider had safeguarding policies and procedures in place and staff had received safeguarding training. The staff we spoke with demonstrated a satisfactory understanding of the different types of abuse that people who used the service could experience and how to recognise signs that a person was at risk of abuse or harm. Staff understood about how to whistleblow within the organisation and to external organisations. Whistleblowing is when a worker reports suspected wrongdoing. However, we found that the provider had not informed the Care Quality Commission without delay when a person who used the service was hit by another person and therefore physically abused. The local safeguarding team had also not been notified, although the provider had informed the relevant community mental health professionals.

This demonstrated that the provider did not consistently comply with the legal requirement to inform the Care Quality Commission of safeguarding concerns, to enable us to monitor safety at the service and take appropriate action where needed. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We noted that the provider had systems in place to identify and manage risks associated with people's care. Prior to people moving in to the service, the provider conducted an assessment of their needs and wishes. The care and support plans we looked at demonstrated that detailed information was gathered about people's previous history, so that staff understood about key issues including their social interests, medical history and family composition.

We found that risks to individuals had been identified and assessed in most cases. However, the risk management plans did not consistently contain the required level of detail to provide sufficient guidance for staff. For example, where people were at risk of self-harm there was no detailed risk management plan in place. In one instance there was no risk assessment in place at all in relation to one person who put themselves at significant risk meeting people through social media and risks in relation to sexual health had not been fully considered to ensure people received support and guidance to help keep them safe. In addition, there was limited information about how staff should support people in relation to alcohol misuse. There were crisis guidelines for staff to follow if a person was at immediate risk of harming themselves or others which included de-escalation, ensuring other people were removed from the situation and calling for support from emergency services.

Records showed that the provider had implemented specific measures to protect people from the risk of fire. This included monthly fire evacuation drills, and regular checks by staff and professional maintenance by external contractors in relation to smoke detectors, fire extinguishers and the manual call points. The landlord's gas safety certificate, the electrical installations certificate and the portable appliances testing

schedule were all up to date and evidenced that there were no concerns. However, we found that the provider had failed to ensure that all risks in relation to fire safety had been fully assessed and mitigated. For example, there was a wooden shed that was used as a smoking shelter in the garden. The provider told us they had not checked that this met fire safety requirements.Following the inspection the provider informed us that a fire safety officer from the London Fire Brigade had subsequently visited one of the provider's service's that had the same type of shed and did not have any concerns. In addition the fire risk assessment for the service did not contain sufficient information to demonstrate that all fire safety risks relevant to the service had been fully assessed and mitigated. We noted that the provider had a policy permitting the use of e-cigarettes in the service, but this had not been risk assessed to determine if this was appropriate and how any risks would be mitigated. The provider said that no-one was currently using e-cigarettes but said they would look into this. We found that the fire policy was generic and referred to the 'care service manager' which was not an applicable role at the service. It was not signed and dated, and did not have an identified review date.

The provider did not demonstrate that processes to fully identify and comprehensively address risks to people's safety were sufficiently rigorous. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The staffing levels were sufficient to meet people's needs, and enable staff to support people to attend health care appointments and social events. On the first day of the inspection people who used the service went out for lunch with a member of staff and on the second day of the inspection a person told us that they were going to a West End theatre show with the recovery manager. Staff told us that they felt able to spend time talking with people and they were encouraged by the provider to support people to engage in community activities by accompanying them to local amenities and shopping centres, if required.

Robust procedures were in place to check the suitability of staff before they started work at the service. Staff records contained evidence of Disclosure and Barring Service (DBS) checks, two verified references, proof of identity and their right to work in the UK. The DBS provides criminal record checks and barring functions to assist employers to make safer recruitment decisions. Any gaps in employment had been explored.

We looked at the provider's medicine system to check if medicines were safely managed. There were clear protocols in place to receive medicines, which were stored securely and at the correct temperature in a lockable cabinet within an office. Staff confirmed that there were no controlled medicines or medicines that needed to be stored within a refrigerator at the time of the inspection. Records showed that staff had received medicines training, which included an assessment of their competency prior to being permitted to administer medicines.

The medicine administration record (MAR) charts we checked had been appropriately completed and individual medicine profiles had been created so that staff had information about people's medicines and whether they had any relevant allergies. The operational manager showed us records that demonstrated daily, weekly and monthly checks to ensure that the stock balanced and there were no gaps where medicines should be signed for. Where medicines were prescribed on an 'as and when' basis (PRN), there were written instructions for staff to adhere to, so that these medicines were safely administered. We noted that one person was self-administering a prescribed medicine; however there was no risk assessment in place and no written evidence that the decision to support the person to self-administer this medicine had been discussed with a health care professional involved in their care and treatment.

We recommend the provider seeks advice from the Royal Pharmaceutical Society guidelines to safely support people who wish to self-administer medicines.

Systems were in place to protect people who used the service from the risk of infections and illness due to cross contamination. Staff were provided with personal protective equipment including disposable gloves and a cleaning rota had been implemented. We observed that the premises were clean and free from malodours, however we observed that food safety guidelines were not always followed. Foods that had been opened did not always have a date of opening so that staff and people using the service knew when these had expired. We also observed that people who use the service were provided with cotton towels for hand drying in the communal toilets, as opposed to disposable paper towels. This practice increased the risk of bacteria breeding due to the cotton towels retaining moisture.

The provider had systems for recording and analysing accidents and incidents, so that any trends could be identified and action taken to minimise the risk of reoccurrence.

Requires Improvement

Is the service effective?

Our findings

We received positive comments from people who used the service and their relatives in regards to the skills and knowledge of the staff team. One person told us that they had been supported by staff to develop household skills and they were pleased about their achievements. Another person told us that their life had been difficult before moving to the service and was now much better.

We looked at how the provider supported staff with their training and development to enable them to effectively support people who used the service. The staff completed an induction checklist that covered health and safety, daily routines, and policies and procedures. This was limited in detail and staff did not complete the Care Certificate. This is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sector, and is offered to staff who are new to the sector.

Staff had received support to achieve national vocational qualifications in health and social care up to level five and mandatory training was in place in a range of subjects including health and safety, understanding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, administering medicines, fire safety, infection control, food hygiene, first aid, safeguarding, mental health awareness and behaviour that challenged. However, staff did not receive additional training in specific topics in relation to the individual needs of people using the service such as epilepsy, drug and alcohol misuse, sexual health or more in-depth training about the needs of people with particular mental health diagnoses. There was some information noted about particular health conditions in people's files for staff to read, for example, non-epileptic seizures. One member of staff told us that they read this information and found it useful.

Staff received supervision every one to two months and we saw that appraisals had taken place for all staff to explore their performance since working at the service.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA. The staff we spoke with demonstrated a suitable understanding of the principles of the MCA and discussed the importance of supporting people to make their own decisions, where possible. We confirmed that none of the people who used the service were subject to a DoLS application or authorisation at the time of the inspection.

There was evidence that people had signed agreement to their care and support plans and that their consent was sought. People had also given consent for photographs to be taken and had given permission

for staff to open their post where this was appropriate. However, it was noted that there were rules imposed in terms of bedtimes, mobile phone use and alcohol was banned from the premises, despite there being little to indicate that these issues had been fully explored with people to ensure that they agreed to these rules or that best interests assessments had taken place where people didn't have the capacity to agree. The provider had sought people's views and their consent to have a cat for the house.

People had been supported to meet their general health needs. One person told us that they attended some appointments on their own for routine health care needs and a member of staff accompanied them to more significant medical appointments. The provider had spoken with people about giving up smoking within a group meeting and leaflets were available within the premises. However, we did not find evidence of discussions with people about smoking cessation within their care plans. Discussions about smoking cessation would be expected to be conducted on an individual basis, so that people have privacy to confidentially discuss their views, concerns and perceived obstacles to giving up smoking. For example, people may not wish to publicly disclose information about their own health and/or relevant health care conditions within their family.

One person had been supported to go to the opticians and get new glasses and another person had been successfully supported to have treatment at the dentist. Health care appointments were recorded there were details about the outcome of these appointments and any required follow up. Care Programme Approach (CPA) meetings were arranged and taking place to ensure people received appropriate multi-disciplinary support with their mental health needs. The Care Programme Approach is a way that services are assessed, planned, coordinated and reviewed for people with mental health care needs.

People who used the service told us they liked the food and enjoyed going out for café and restaurant trips arranged by staff from time to time. One person said, "I have done some cooking for everyone and do my own shopping." Although people's care records emphasised the need to encourage people to eat healthily we noted that the majority of the food stored in the home was processed, fast food such as ready meals and microwave burgers. It is acknowledged that people bought their own food. We noted that one person was making significant progress in relation to their weight management goal. One person had attended a healthy eating cookery course and staff had conducted individual discussions about healthy eating with people who use the service.

People who used the service and their relatives commented on the pleasant and comfortable environment that people were provided with. One relative said, "[My family member] had an ensuite which [he/she] really likes and it gives [him/her] privacy. It is a beautiful home, absolutely brilliant, a home from home." Another relative stated, "It is comfortable, homely and clean." We noted on the first day of the inspection that a bed in a vacant bedroom was placed on a raised level, which might not be suitable for people with specific mobility and/or health care issues. Following the inspection we were informed by the provider that the bed was positioned in order to accommodate staff attending meetings in the vacant room. On the second day we were shown that the bed had been moved within the room to the regular floor level. We also observed that a heavy mirror was not securely attached to the wall in the lounge and potentially placed people, staff and visitors at risk if it dislodged from its position. This finding was discussed with the registered manager so that remedial action could be taken.

The provider informed us that they had opportunities for working in partnership with other organisations as part of their own development, and with the aim of continuously improving the care and support they provided for people who used the service. For example, the registered manager told us that the service had introduced an internal mental health residential pathway and had been asked by a local authority commissioning team to share this learning with other providers. This was part of a formal project to enable

people to progress with their mental health recovery and move on to more independent types of accommodation.

Good

Is the service caring?

Our findings

People we spoke with informed us they were happy living in the home and we saw they were at ease with staff. We observed positive and cheerful interactions between people who used the service and the staff team. Comments included, "[The staff] are bubbly, laughing and smiling, this house is beautiful, it's brilliant" and "We have some fun here, I won the bingo last time. My family say it is great here." Relatives commented, "I wish there were more places like this for people to live in when they leave hospital, the staff are great with [him/her] and "They (staff) are lovely people and have looked after [my family member] with kindness and always let me know what is happening."

Staff spoke in a sincere way about the people they supported. One member of the staff team told us they had previously worked with adults with a learning disability but had wished to work with people with mental health care needs as they had personal experience of supporting a member of their own family. The registered manager confirmed that she had appointed other staff within the organisation with similar long-term backgrounds as informal carers because of the genuine interest they had in the wellbeing of others, and their caring and warm personalities.

The care and support plans we looked at showed that people were asked about their needs and wishes, and staff demonstrated a good level of knowledge about people's likes, dislikes, preferences and aspirations. People who used the service were encouraged to sign their care and support plans to show that they had been contributed to the discussions about their goals. As the service had been operative for slightly less than one year at the time of the inspection and people who used the service had moved in at different stages, we did not expect to find extensive evidence of reviews having taken place. The people we spoke with understood that their views were valued by the provider as part of any reviews of their care and support.

Staff told us that the aim of the service was to support people to develop their independent living skills and increase their confidence so that they could move on from a care home setting to other types of accommodation, for example supported living houses and flats in the community. Our conversations with people who used the service demonstrated that people felt they were being encouraged to make day to day choices and other decisions about their lives, and they were pleased with how staff encouraged them to achieve new skills. One person told us that they were now going out grocery shopping without staff support and another person told us that staff had supported them to embark on a college course. People told us about the various difficulties they had encountered over the years due to their mental health needs and they were justifiably pleased about the achievements they had made since moving into Fairlawn.

During the inspection we saw how staff supported people to maintain their dignity and privacy. For example, staff knocked on bedroom doors and asked people for their permission to enter. People were asked by staff if they wished to speak with us and which room they preferred to meet us in. Although staff demonstrated that they had developed good relationships with people using the service, some of the language used in people's care records did not show respect for people. For example, when talking about an improvement in a person's self-care a member of staff had written "[Person using the service] smells a lot better now". Confidentiality was not always appropriately maintained or considered. For example, it was noted that

personal information had been discussed with people at group meetings such as their wish to self-administer their medicines and people's future plans.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and the relatives we spoke with told us that staff understood how to meet their needs. One relative told us that they only had to look at how well their family member had progressed to appreciate that staff understood how to meet people's needs and aid their mental health recovery.

The care and support plans we looked at showed that people's needs had been appropriately assessed before they moved into the service. Information had been sought from health and social care professionals about people's past history and current needs, and the provider had carried out their own pre-admission assessment before people moved in for an initial trial period. People's care and support plans contained details of the goals they wished to achieve and the proposed actions to support people to develop their independence, learn new skills and/or regain skills that could enable them to lead a more fulfilling life. These plans were up to date and kept under review. We noted that there were some positive examples of how these care and support plans had been written in an individual way. One person had a specific term they used to describe how they felt at times and this was recorded so that staff could sensitively respond and provide the person with additional reassurance and understanding when necessary.

Activities were arranged but these were limited. People were supported to attend a local gym, go bowling, join nature walks and attend a gardening group. One person attended a cookery course at college and another person was supported to play football, in line with their wishes. Staff supported people to develop their literacy and numeracy skills at home, if people wished to. However, it was noted that in the records some people had not yet been supported to attend activities of their choosing. The same person had identified in their care records that they would be interested in visiting an aquarium but there was no evidence to suggest that this had been explored further.

Care and support plans detailed people's needs and relevant information about their history in relation to their mental health needs, family relationships and likes and dislikes. There was information to demonstrate that staff had taken the time to get to know people and build relationships with them in order to support their recovery, however there was a lack of attention to detail in the guidance for staff about how to meet people's needs. For example, one person had a history of overspending and their care and support plan stated that staff should support the person with their budgeting but there was no information about how staff were to do this. There was a review record showing that care and support plans were reviewed on a monthly basis. This stated whether or not any changes were made to people's care and support plans.

People who used the service told us that they did not have any concerns or complaints about the quality of the service. The relatives we spoke with confirmed that they too did not have any concerns or complaints, and they expressed their confidence that any issues would be dealt with in a professional and helpful manner by the provider. There was a clear and accessible complaints policy in place with timescales for response, which included information about anti-discriminatory practice and confidentiality. However, the policy inaccurately stated that people could refer their complaints to the Care Quality Commission (CQC) if they were not satisfied. CQC does not investigate individual complaints. Details of the role and responsibilities of the complaints ombudsman and the contact details were not included. There were no

recorded complaints for the service.

The care and support plans we looked at did not have information about people's end of life care needs and wishes. End of life care was not applicable to the people who used the service at the time of the inspection and it was recognised that staff would wish to develop relationships with people over a period of time before broaching this type of conversation.

Requires Improvement

Is the service well-led?

Our findings

We saw that people who used the service had a good relationship with the registered manager. One person told us that they had been out for lunch recently with the registered manager and they felt happy in her company. The relatives we spoke with stated that the service was well managed and they could speak freely to the registered manager. We noted that there were complimentary letters on display in the staff office from local health and social care professionals who had knowledge of the service. One health and social care professional told us, "We have no concerns. All of the inspections to the local homes in Greenwich have been good and we generally have a positive working relationship with [provider]."

The registered manager spoke with us about the provider's aims and vision during the inspection. The provider's public website stated, "We specialise in intensive rehabilitation to support and guide our residents along the care pathway to lower support or independent living. We focus on all aspects of the residents' recovery from mental, physical, social, personal care, family contact and safety, integrating them into society to have a meaningful and happier life." The registered manager told us that she had completed a management and leadership diploma and was now supporting other staff within the organisation to complete this qualification, as staff professional development was key to the continuous progress and improvement that she sought to achieve for the benefit of people who use the service.

Quality monitoring systems were in place. The registered manager's spot checks were taking place on a monthly basis, however the records relating to these were limited. Comments such as "staff interact with service users" and "staff talked to service users respectfully" were noted, but there was no further information about what they observed or what they checked during the visit and no recommendations had been made. The provider's annual audit of the service was not due until August 2018, as the service had not been operative for a year at the time of the inspection.

There were also quality audit forms in place but again these were limited as they did not record what was checked or provide any detail about what was found. There were comments such as "all okay", and 'not applicable' had been written in terms of 'non-compliances' and 'corrective action required'

There was a quality assurance home checklist in place that looked at all areas of the environment in terms of cleanliness and maintenance issues. This had been completed monthly and no issues had been found, and there was also a security risk assessment form in place looking at the security of the premises. The provider told us that no audits were completed for records as she completed the records alongside the operations manager and therefore there was no need. However, issues that we had identified in the records had not been identified by the provider.

People were asked for their views of the service, along with relatives and healthcare professionals. Feedback had been positive and the results of surveys had been analysed to see if any action was needed. The most recent surveys had been completed in March 2018. One comment from a health care professional stated "staff are professional, kind and informative." One relative had written "I feel that the staff are friendly and that they look after [my family member] well and that [my family member] is happy" and another had said

"we are very happy with the service". Service user meetings were taking place monthly and minutes were taken. We saw that people were asked for their views about activities.

Staff meetings were also held monthly and a range of issues were discussed such as meal provision and encouraging healthy eating, medicines and activities. A staff member told us they felt well supported by the management team. It was noted that on two occasions people using the service had been invited to the staff meeting. On one occasion this was to discuss with the person their need to protect themselves from exploitation by others and another to encourage them to follow the house rules. This may have made people feel uncomfortable and may not have been an appropriate forum to explore these issues with people.

We found that the provider did not always demonstrate a comprehensive understanding of Care Quality Commission (CQC) requirements. Records showed that the police had been called to the service on one occasion, which had not resulted in a notification being sent to CQC as stipulated by legislation. This impeded CQC from monitoring the safety of people who used the service.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents People's safety was not protected through the provider informing the required authorities about safeguarding and incidents reported to or investigated by the police. 18(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected by the provider consistently assessing the risks to their health and safety and doing all that is practicable to mitigate any such risks. 12(1)(2)(a)(b)