Clover Residents Limited

New Beginnings Residential Care - 2 Dorchester Drive

Inspection report

2 Dorchester Drive
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Tel: 02088931123

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 25 April 2017 and was unannounced.

The last inspection took place on 16 January 2017, when we found breaches of six Regulations relating to notifications of incidents, person-centred care, safe care and treatment, safeguarding people, good governance and staffing. We issued a warning notice for breaches relating to the safe care and treatment of people and we made five requirements. The service was rated Requires Improvement, with the key question of Safe being rated Inadequate. The provider wrote to us to state that all the required improvements would be made by March 2017. At the inspection of 25 April 2017 we found that there had not been any improvements in some areas and not enough improvements in other areas. We could not make a judgement about notification of incidents because there had not been any such incidents since the last inspection.

New Beginnings Residential Care - 2 Dorchester Drive is a care home for up to three people. At the time of our inspection three people were living at the service. Two were adults under the age of 65 years who had learning disabilities. The third person was an older person living with the experience of dementia. People living at the service had limited communication skills because of their disability or condition. In addition one person did not speak English as their first language. The service was managed by Clover Residents Limited, a private organisation who ran two other care homes in North West London.

The registered manager left the organisation in August 2016. There was a new manager in post. They had started the process of applying to be registered with the Care Quality Commission. 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.

People who lived at the service were not always safe. The provider had not ensured that all risks were appropriately assessed or that plans were in place to mitigate these risks. The arrangements relating to fire safety were not sufficient and people were at risk in the event of an emergency situation. The staff were not deployed in a safe way and worked excessively long hours without sufficient breaks, placing people at risk.

There had been improvements in the way medicines were stored although further improvements were needed for the storage of controlled drugs. People received their medicines in a safe way, although the protocols for the administration of PRN (as required) medicines were incomplete leaving the decision about whether to administer these to the judgement of staff who were not trained to make this decision.

People were being unlawfully restrained and their freedom and rights restricted without proper authorisation. For example, the staff physically restrained one person when providing personal care in order to prevent injury to the person and staff. This had not been properly assessed or planned for and incidents of restraint were not recorded or investigated. People were administered medicines covertly (without their

knowledge). The provider had made this decision without proper assessment or best interest planning.

New staff were not given the information and support they needed to care for people and to keep them safe. Experienced staff told us they received training and support, however there was insufficient documented evidence of this.

People were not supported in a way which met their needs and reflected their preferences. They did not have fulfilling lives nor were they supported to try new things, access the community or achieve their potential.

The service was not well-led. The provider had failed to address and take enough action regarding the concerns we identified in January 2017. The provider's action plan following the inspection of January 2017 and evidence of their discussions with staff about the outcome of the inspection indicated they had misunderstood the seriousness of some of our findings. Records had not been completed, were not accurate or were not available at the service.

The majority of interactions we witnessed between the staff and people who they supported were not unkind, but were task based and did not take account of people's individual needs or preferences. We spoke with one relative who told us they thought the staff were kind and caring. We also received positive feedback about the staff approach from two other relatives who we spoke with in January 2017.

Following the inspection visit we asked the provider to supply us with assurances about how they would alleviate the risks we considered to be extremely serious. They sent us an action plan telling us they would address these risks by 15 May 2017.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this provider is 'Inadequate' with the key questions of safe, effective, responsive and well-led rated 'Inadequate.' This means that the service has been placed into 'Special Measures' by CQC.

The purpose of special measures is to ensure that providers found to be providing inadequate care significantly improve, provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. To provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

The provider had not taken adequate steps to make sure people were safe in the event of a fire.

The risks for each person had not been fully assessed and the provider had not mitigated against these risks.

People were being unlawfully restrained.

The staff were not deployed in a safe way.

We could not judge whether staff had been recruited in a safe and appropriate way because there were not enough records to evidence this.

Is the service effective?

Inadequate

The service was not effective.

The provider had placed restrictions on people's freedom without proper assessment or authorisation.

The staff were not appropriately skilled, competent or knowledgeable and could not effectively meet people's needs.

People's nutritional needs were not always being met.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

The staff were generally kind when speaking with people, but their interactions were not always appropriate, demonstrated a lack of empathy, were task based and limited to a few sentences at a time.

The staff did not use touch, objects of reference or any non-verbal methods of communicating or supporting communication.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always being met. The way in which care was provided was not person centred and did not reflect nationally recognised good practice guidance.

People were not supported to participate in meaningful activities which offered stimulation or interest.

With the exception of a small amount of visits to the local shops for one person, people were not supported to access the community.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to assess, monitor and mitigate risks to people living at the service.

The provider did not assess, monitor or improve the quality of the service.

The provider had failed to respond to the requirements and action issued at our previous inspection.

New Beginnings Residential Care - 2 Dorchester Drive

Detailed findings

Background to this inspection

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

This inspection took place on 25 April 2017 and was unannounced.

The inspection was conducted by one inspector.

Before the inspection we looked at all the information we held about the provider. This included the last inspection report, the provider's action plan for meeting requirements and other evidence they had shared with us.

During the inspection we met all three people who lived at the service. They could not describe to us how they felt about living at the service. We observed how they were cared for and treated. Our observations included a Short Observational Framework Inspection (SOFI) during the morning. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We spoke with four support workers who were on duty. We also met and spoke with one visiting relative.

We looked at the records for all three people, including care plans, risk assessments and records of care provided. We looked at other records the provider used for managing the service and these included the training records for three members of staff, recruitment and support records for three members of staff, the staff communication book, the staff signing in book, the provider's policies and procedures and records of checks made by the staff on the environment. We looked at the environment and how medicines were being managed, stored and recorded.

Following the inspection visit we requested the provider sent us some records which were not available at the location. These included the staffing rotas, evidence of team meeting minutes, evidence of fire drills, evidence of the provider's insurance and evidence of further checks on the health and safety of the environment. We were sent these.

On 5 May 2017 we requested further information from the provider in the form of an action plan telling us how they would respond to risks of extreme seriousness which we identified. The provider sent us this action plan on 9 May 2017.

Inadequate

Is the service safe?

Our findings

At the inspection of 16 January 2017 we found that information about managing risks and supporting people had not always been reviewed and did not reflect current risks or practice. The arrangements for keeping people safe in event of a fire were not suitable. We issued a warning notice telling the provider they must make the required improvements by 10 March 2017.

At the inspection of 25 April 2017 we found that some improvements had been made but there were still areas of risk for people living at the service which had not been properly managed.

The procedures at the service did not adequately ensure that people would be kept safe in event of a fire. For example, the front door was locked by a key pad system which was not linked to the main fire alarm system. The risk assessment for one person stated, ''All members of new staff must ensure they know the pin code for the front door.'' We found that this was not the case. One of the two members of staff on duty when we arrived at the service for our inspection had worked at the service on one previous occasion (for a few hours) and had been working for one and a half hours at the time we arrived for the inspection. They were unable to open the front door, and when we were allowed entry they told us they did not know the pin code for the door. The staff took ten minutes to open the front door to let us into the building. A more experienced member of staff who did know the pin code was in a different part of the building behind another locked door. This meant that in an emergency situation the new member of staff may not have been able to open the only accessible fire exit.

At the inspection of 16 January 2017 we found that there were not personal emergency evacuation plans (PEEPS) in place for the people who lived at the service. PEEPS are person specific instructions for the staff so that they know how to safely evacuate each person who lived at the service. The service manager created PEEPS and sent us copies of these in March 2017. However, on the day of the inspection the PEEPS were not available at the service. One member of staff told us they had once seen the PEEPS but they were not able to tell us what these said. The other two experienced members of staff who we met during the inspection had not seen the PEEPS and one member of staff told us, ''Perhaps these are kept at head office.'' The newest member of staff had not seen the PEEPS.

The PEEPS did not include information about individual needs or the specific support the people would require. Two of the PEEPS were identical despite the fact that one of the people had refused to evacuate the building at least twice when the fire alarm had been activated. The PEEP made no reference to this or how the staff should respond if there was a fire and this person refused to leave the building. We asked the staff what they would do in this situation and they said that they did not know. Two people living at the service were able to walk unaided. The staff on duty told us the third person was able to walk only very short distances (from their bedroom to the bathroom) with the aid of a walking frame and two members of staff. There was no reference to this mobility need in the person's PEEP. The PEEP stated, ''Once the alarm goes off, staff would go to [the person's] location and support [them] out of the building.''

There were just two members of staff on duty at the service from 8am – 11am on the day of our inspection

and one of these members of staff had worked at the home once before. We asked this member of staff how they would support people in event of a fire or emergency situation. They told us they did not know. They said that none of the experienced staff or the manager had explained the fire procedure or showed them what to do. They said that they had tried to read the notice board (situated in the hallway) to understand the fire procedure. The notice on the board was basic and general information and did not explain how each person who lived at the home should be supported.

During the inspection of 16 January 2017 we saw that at least one of the bedroom doors was held open by a wedge which prevented it closing in event of an emergency. We spoke with the service manager about this on the day of our visit. They agreed that this practice was unsuitable and they would consider purchasing a device to hold the door safely open. When we returned on 25 April 2017 we found that the door was still being held open by a wedge. The occupant of this room was unable to move without staff support. Therefore they would be unable to close the door which could prevent the spread of fire and smoke.

The building was a bungalow and had three exits. One exit was situated in the kitchen and another in the staff office. People in bedrooms and the lounge could only access these exits via the kitchen. At times during the day and night the kitchen door was locked with a key. We saw that the staff locked the door and left the key on a kitchen work top. This could only be accessed by the staff on the kitchen side of the door. The risk assessment for one person who lived at the service included the statement, ''Staff to have keys in position at all times when in the home.'' It was not clear what this meant or how staff could maintain safe access through this locked door. The fire procedure and risk assessment did not include reference to this procedure. In a situation where the key was misplaced or something happened to the member of staff on the kitchen side of the door others would not be able to access this area. On our arrival at the home the only member of staff in the same part of the building as people who lived there was unable to open the only accessible exit, the front door, because they did not know the code.

The provider's risk assessment for the service had been written in 2013. It had been reviewed annually up until January 2016 but not since this time. The service manager showed us a letter which demonstrated they had arranged for an external company to carry out a fire risk assessment on 3 May 2017. There was no evidence of any other assessment of fire safety risks.

On 16 January 2017 we found evidence of two recent planned fire drills and one unplanned evacuation resulting from burnt food setting off the alarms. The incidents in September 2016 and November 2016 recorded that one person had refused to leave the building. The incident in December 2017 stated it took eight minutes to evacuate the building. During our visit on 25 April 2017 there was no evidence of recorded fire drills since this time and the records of the evacuations in 2016 were not available. We asked an experienced member of staff on duty whether there had been any fire drill practices since our last inspection. They told us they did not know and there had not been any whilst they were on duty. Following the inspection the service manager sent us a record which stated there had been two fire drills since our last inspection, in February and March 2017. The record stated that the service was evacuated once in three minutes and one in two and a half minutes. There were no other details about the evacuations.

Up until January 2017 records showed that the staff were routinely checking fire alarms, fire doors, emergency lighting and carbon monoxide alarms. The last test of these systems by the staff was on 3 January 2017. The staff on duty were not able to tell us who was responsible for making these checks. They told us that they did not need to test equipment because this was carried out by an external company. Records indicated that the external company carried out annual fire alarm checks only. The most recent of these had been in March 2017 and only covered the fire alarm system. The last check of fire doors in January 2017 stated that the office door was not closing properly. We observed this to still be the case during the

inspection of 25 April 2017. There was no evidence to show whether any action had been taken in respect of this.

Therefore we judged that the registered person was not providing safe care and treatment for the people who lived at the service.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following receipt of the draft report the provider has told us that they have taken action to address some of the concerns around fire safety which include updating the PEEPs and fire safety risk assessment. The London Fire Protection and Safety authority visited premise to inspect fire safety systems in May 2017. They wrote to the provider regarding their findings and areas where improvements were needed.

Since receiving the draft inspection report the provider has told us that all staff know the pin code entry for the front door. They told us that the member of staff on duty at the time of the inspection had temporarily forgotten the code but did not want to admit this.

Since the last inspection the service manager had created a risk assessment for each person who lived at the service. In an email they sent us shortly after the inspection visit they stated, ' Risk assessments have been updated and reflect current circumstances.'' We found that the risk assessments did not sufficiently identify the risks people were exposed to. Nor did they give enough information about how people should be supported when they were at risk. For example, one person's file included a review from the local authority which was carried out in July 2016. A copy of the report from the review was sent to the provider on 10 January 2017. The review included this information, ''[Person] requires support from three support workers for all transfers using hoist.'' We saw that there was a hoist and sling in the person's bedroom. The staff on duty told us that the person could move short distances without the support of a hoist, using a walking frame and with staff support, depending on their condition each day. The staff member told us the person sometimes used the hoist. None of the care planning information or risk assessments for this person written by the provider included reference to the hoist. There was a bath chair which could be electronically moved to support a person to get into the bath. The staff explained that they used this to support this person to access the bath. The risk assessment for the person, dated February 2017, stated, ''Staff to assist [person] getting into the bath, making sure [they are] able to hold onto the step and grab handles supplied in the bathroom.'' The risk assessment also stated the person should ''Get out of the bath using the step and grab handles.'' The risk assessment did not contain any reference to the bath chair. There was no evidence the person had been assessed since the local authority review in July 2016 by an appropriately qualified professional who could make judgements about how the person could be safely moved.

The provider had created a single risk assessment for each person which covered a range of different risks. The information about the hazards and hazard controls was not sufficient. For example, one person had a single risk assessment covering the following identified hazards: Hot food preparation/cooker, sharp utensils and knifes, taking food from the communal fridge, security, safety when out in the community, damage to property, indecent exposure, road sense and personal care. The risk assessment document included a bullet point list of instructions. These did not follow a specific order and some instructions were unclear. For example, the record included a bullet point about how staff should respond if the person sat down in a road with the following statement, ''Ensure safety. Remove items where possible. Staff to encourage [person] to [their] room to enable [them] to calm down. Two staff to remain close to [person] at all times with enough space that [person] can calm down. Offer snacks to [person] or play [their] favourite music.'' The document then went on to describe how the person should be supported in the community

and then how they should be supported in a bath.

There were no recorded hazard controls for some of the identified risks. For example, one person's risk assessment identified a risk recorded as, ''hot food preparation/cooker, sharp utensils and knifes, taking food from communal fridge.'' There were no action points relating to this in the ''hazard control'' section of the document. The only reference to this risk in the document was under a section entitled, ''Further action required'' where the document stated, ''Kitchen door must be locked when in use.''

One person had epilepsy, a condition which caused seizures. There was no reference to the risks associated with this condition in the person's risk assessment or their care plan. The person's risk assessment had one reference to the condition under the section, ''Hazard controls'' where the document stated, ''Protocols of event should be followed should in case [person] has a seizure.'' This point was immediately followed by an unrelated reference to supporting the person when they exhibited behaviour that challenged.

A document entitled, ''needs assessment'' for one person included a section entitled, ''daily living skills and self-care.'' The record was not dated but had been created by the service manager since the last inspection. The record stated, ''I am unable to do most things for myself…I accept help most of the time.'' The same document included a section entitled, ''mental state.'' In response to the question, ''confused?'' The service manager had recorded, ''Yes and no. At times can become verbally aggressive to [themselves] screaming that someone is hitting [them] while talking to voices in [their] head.'' In answer to the question, ''aggression?'' the service manager had written ''No.'' However, in another part of the document entitled ''stability/mental state/mood'' the service manager had written, ''At times can be verbally aggressive to [self] and others, shouts, screams. Also indicates that someone is hitting [them] when no one is there. Can accuse others of violence towards [them]. Can be physically violent to others.'' The person's risk assessment dated February 2017 and also written by the service manager, made only one reference related to aggression or non-compliance with care when they had recorded, ''If [person] refuses to comply with personal care staff are to explain to client regarding maintaining [their] personal hygiene and ask [their] permission to give [them] a bed bath.'' The staff on duty explained that this person was frightened of water and was resistant to having baths and some personal care interventions. They told us that two or three members of staff were required to support this person with personal care and that the person regularly hit and scratched the staff and themselves. There was no reference to their fear of water or the need for two to three staff within the person's risk assessment or needs assessment documents. Some of the challenges in caring for this person were recorded in a review made by the local authority, a copy of which was held at the service and stated, ''Prefers bed baths. Sometimes non-compliant with personal care and can become physically and verbally aggressive towards staff. Staff manage this with distraction techniques and general reassurance.'' There was no care plan in respect of this.

The staff recorded incidents of aggression and challenges. We saw that there had been five recorded incidents in April 2017 and four in March 2017 where the person had scratched, kicked or punched staff, screamed and injured their self, including incidents where they had broken the skin on their legs by scratching.

Therefore we judged that the provider had not sufficiently identified risks to people or done all that was reasonably practical to mitigate these risks.

This was a further repeated breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We judged the risks described above as extremely serious and we contacted the provider to ask for

assurances that they would take immediate action in response to these. The provider wrote to us telling us they would take action by 15 May 2017.

Since receiving the draft inspection report the provider has told us that they have reviewed and updated risk assessments. The provider also said, ''As the provider did not receive the [local authority review for six months] care plans or support plans will possibly contain outdated information.''

At the inspection of 16 January 2017 we found that people were placed at risk of unlawful restraint, abuse and harm from this. The staff described how they restrained one person to prevent them from hurting themselves and others. This was confirmed by the person's relatives. The provider supplied us with an action plan telling us they would make improvements by February 2017.

At the inspection of 25 April 2017 we found that the person was still being unlawfully restrained. The staff described and demonstrated how they held one person's arms to restrict their movement when they were supporting the person to wash and with personal care. They told us that between two and three members of staff were needed to provide personal care to this person and that at times the person hit and scratched their self and staff.

The provider's policy on ''responding to behaviours that challenge'' had been created in February 2017. The policy stated, ''Physical intervention should only ever be used as the last resort….if employed [restraint] should be with clear guidance [the use of restraint], and alongside a range of other ways supporting that person.'' The policy went on to say that the use of restraint would be subject to regular reviews with ''the clear aim of eliminating [the use of restraint.]'' Under the section, ''Things we do'' within the policy the provider had written, ''Completing a behaviour…support plan'' which would be ''discussed in any review.'' The policy stated that the plan would outline the behaviour and response.

The provider had failed to follow their own procedures and had also failed to safeguard this person from the abuse because they had not provided written guidance for the staff on how to provide care in a safe way in order to meet this person's needs. They had also failed to record incidents of restraint and analyse these to make sure these incidents had been the last resort and been carried out in the least restrictive way.

This was a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection of 16 January 2017 we found that the staff worked long hours without sufficient breaks and time off work and this placed people at risk. We made a requirement in respect of this. The provider supplied us with an action plan telling us they would have made the necessary improvements by March 2017.

At the inspection of 25 April 2017 we found that staff were still working long hours without sufficient breaks. There had been some improvements in this area. For example, two staff worked at night at the service. One member of staff was waking and the other slept at the service, being available if needed. At the previous inspection we found the member of staff who was sleeping at the service was doing so in the lounge which was also used by the waking member of staff and people who lived at the service during the night. At the inspection of 25 April 2017 the staff told us they used a fold away bed in the office. We saw there was a fold away bed available.

We looked at the staff signing in and out book for the month of April 2017. The staff told us they were required to write the time they started and finished work at the service. However, we noted that this was not always being accurately maintained, because a member of staff on duty on the day of our inspection had

signed themselves out at 9am in the morning, but they were still working at the service at 3pm in the afternoon. The staff told us they did not record breaks in the book. They confirmed that they took any breaks during a shift by sitting in the office and they did not leave the building.

The staff signing in book for April 2017 showed that one member of staff had started work at 3pm on 31 March 2017 and had not left the service until 9am on 4 April 2017. They had the role of the sleeping member of staff for four nights in a row, working from 7am until 9pm each day in between. The staff member worked the same hours again from 3pm on 7 April to 9am on 11 April. This person worked the same pattern of shifts throughout the month, taking two days off work and then working a six hour shift followed by four sleeping in duties and three fourteen hour days before leaving on the morning of the fifth day. The member of staff was on duty on the day of our inspection. They had started work at 3pm on the 21 April 2017 and were due to leave at 9am on 25 April 2017, but did not leave because the replacement member of staff did not arrive for work. They were still working when we left the service at just after 3pm on 25 April 2017.

We requested the rotas for March and April 2017 from the service manager because these were not available at the service. They provided us with the rotas for two different weeks; 27 February 2017 to 5 March 2017 and 3 April to 9 April 2017. They told us that these were ''rolling rotas'' and the pattern of working was repeated each week unless the staff requested time off. We saw that the rota recorded that one member of staff was always scheduled to work from Friday 3pm until Tuesday 9am. Another member of staff was scheduled to work from 7am on Tuesday until 7am on Thursday with two sleeping in duties one week and from 7am on Tuesday until 8pm on Thursday with two sleeping in duties the following week, followed by two twelve hour shifts on Friday and Saturday and one thirteen hour shift on Sunday of that week.

The staff signing in book for April 2017 indicated that other staff had also worked long hours at the service. For example, one member of staff had worked from 8am until 9pm on the 1 April followed by a waking night shift and then from 7am until 9pm on 2 April 2017. We looked at records the waking night staff used to record how people had been during the night. These records confirmed that this member of staff had been the allocated waking staff on the night of the 1 April 2017. The member of staff then worked from 8am until 9pm on 2 April 2017 and a waking night duty starting at 9pm on 4 April 2017. They also worked from 9am on the 11 April 2017 followed by a waking night duty and then worked until 9pm on 12 April 2017.

We saw other examples of staff working long hours without breaks during April 2017. People were placed at risk because the staff were working these long hours including examples of waking shifts lasting 37 hours.

This is a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We judged the risks associated with staff working these long hours as extremely serious and we contacted the provider to ask for assurances that they would take immediate action in response to these. The provider wrote to us telling us they would take action by 15 May 2017.

Since receiving the draft inspection report the provider has told us that the records relating to staff working hours had been incorrectly completed by the staff.

At the inspection of 16 January 2017 we found that people received their medicines as prescribed but these were not stored safely and this put people at risk. We issued a warning notice telling the provider they must make the required improvements by the 10 March 2017.

At the inspection of 25 April 2017 we found that improvements had been made. The provider had purchased

a new medicine cabinet and this had been appropriately secured. They had purchased a new thermometer to check that medicines were stored at the correct temperature and the staff checked the temperature of the cabinet daily. We saw that the temperature on the day of the inspection was within the appropriate range for storing medicines and records indicated that this was always the case.

Medicines were administered in a safe way and the staff demonstrated a good knowledge of people's individual medicine requirements. The staff told us that they had recently attended a training course run by a local pharmacy. There was evidence the pharmacy had audited the medicines and found the arrangements at the service to be suitable. The staff counted all medicines daily and recorded these counts. Medicine administration records were completed appropriately.

Controlled drugs are medicines which are considered higher risk than other medicines and there are specific legal requirements around the storage, recording and administration of these. We found that a controlled drug had been prescribed to one person at the service. The staff kept accurate records of this medicine, but it was stored within a plastic container in the medicine cabinet. The medicine cabinet did not comply with the requirements of the Misuse of Drugs (Safe Custody) Regulations 1973 for the storage of controlled drugs. We discussed this with the service manager following our inspection and advised them that they would need to make additional arrangements to store this particular medicine.

Some people were prescribed PRN (as required) medicines. The staff had created protocols for when these should be administered. However, the documents were not fully completed and did not indicate under what circumstances the staff should administer certain medicines. Some of these were pain killers and people living at the service could indicate when they were in pain. However, the protocols for some of the PRN medicines described the purpose as, ''To help calm down'' and ''To become less agitated.'' However, there was no additional information to tell the staff when it would be necessary to administer the medicines. Therefore the administration of this type of medicine was left to the judgement of individual staff members. This meant there was a risk that they would administer the medicine unnecessarily or under the wrong circumstances.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Areas of the building were not sufficiently cleaned. There was one bathroom, including a toilet and hand wash basin, at the service used by all three people. The taps and shower hose on the bath had limescale deposits. There was black mould on the sealant around the bath. We discussed this with the service manager at our inspection of 16 January 2017 and they agreed to ensure deep cleaning of the bath. However, there was no change to the situation when we returned on 25 April 2017. In addition; we noted that there was no soap available for people to wash their hands, there were no paper towels in the bathroom and the toilet brush holder contained dirty water. There was also a deposit of hair in the bath plug hole.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required to maintain a record of all persons employed at the service including evidence collected as part of their recruitment. This is so they can demonstrate that the staff they have employed are suitable. This requirement also includes the use of temporary staff, where the provider must obtain evidence of their suitability from any recruitment agency supplying the staff. The service manager provided us with a list of eight permanent members of staff who were employed to work at the service. In addition we

noted that one other member of staff had worked at the service during April 2017, because they had recorded information in the waking night records and staff signing in book. There were records of the recruitment for only three of these members of staff at the service. There was no other information available about the other six members of staff.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the inspection of 16 January 2017 we found that the provider had placed restrictions on people's freedom without proper assessment or authorisation.

Two people were administered their medicines covertly (without their knowledge). In December 2016 the GP for these people had written letters in respect of each of them stating, ''In order to improve medication compliance with this patient, there is no contraindication for medication to be [crushed] and given with food.'' In our inspection report from the inspection of January 2017 we wrote about this and stated, ''However, there were no capacity assessments in relation to the decision to administer medicines covertly. In addition, the decision had not been made as part of a best interest process for the individuals.'' We made a requirement because the people were being unlawfully deprived of their liberty without proper authorisation. At the inspection of 25 April 2017 we found that no improvements had been made in respect of this. There were no assessments of people's capacity to make decisions about their medicines. The decision to administer medicines covertly had not been made following the best interest process.

At the inspection of 16 January 2017 we also noted that the kitchen door was sometimes locked preventing people from accessing this room. During our inspection of 25 April 2017 we noted this was still the case and saw staff physically barring the way of one person who was trying to enter the kitchen when the door was unlocked. The staff said that this was for people's safety. However, the only reference to this was in one person's risk assessment which stated, ''Kitchen door must be locked when in use.'' There was no evidence of capacity assessments relating to this decision or evidence that the decision had been made following the best interest process. In addition we noted that the kitchen door was locked when the kitchen was not in use.

This is a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff who cared for people had not always received the support and information they needed to keep people safe and meet their needs. One of the two members of staff on duty when we arrived for our inspection on 25 April 2017 told us they were new to the service. They said that they had visited the service for a few hours the previous week and this was their first full working day. They were one of two members of staff on duty from 8am until 11am and were left on their own with all three people who lived at the service for periods of time whilst the other member of staff was in the office or kitchen. They explained that they had not received any induction into the home and were not aware of basic safety procedures, for example where the fire exits were and how to support people in the event of a fire. They had not read people's care plans or any other records. They told us that they would read the care plans later during the day of the inspection, although they had not done this by the time we left just after 3pm. Three other experienced members of staff were on duty for some or all of the time during our inspection visit. We observed only two occasions when another member of staff spoke with the new staff member about the needs of people who lived at the service. They told the new member of staff that they should, ''Stay in the same room as [person]'', although they did not offer any explanation for this or speak about this further. Shortly afterwards

they told the new member of staff that another person sometimes rushed eating their food. There were no other discussions about people's needs or how to support them.

The experienced staff told us that they undertook online training and that they had recently completed a group training session with a local pharmacy about medicines management. One member of staff told us they thought some of their training was due to expire. We looked at this member of staff's training record and saw that all the certificates for on line training courses they had completed included an expiry date which had passed. We were unable to check whether other staff had completed the training they needed for their role because only two other members of staff had training records available at the service. The records for one member of staff showed some recent training. However, the other member of staff's training had been completed in 2014 and there was no evidence of any updates since this time. There were no training records available for the other members of staff employed at the service.

The staff told us they had taken part in recent individual supervision meetings with their manager. However, there were no records of these. There were supervision records for only three members of staff who were employed to work at the service. The last recorded individual supervision meeting for two of these members of staff was in December 2016 and for one member of staff was in October 2016.

The experienced staff knew people's basic care needs but they did not demonstrate the skills or knowledge to meet people's more complex needs. People were not supported to reach their potential and followed exactly the same pattern of activities within the same environment every day. The staff did not demonstrate an understanding of how to support two people who were on the autistic spectrum or one person who had dementia. They had not received recent training in these areas and did not show any awareness of people's sensory needs or demonstrate they understood good practice guidance for meeting these particular needs. For example, the staff did not understand how to communicate with people. For the majority of time the staff did not communicate with two of the people who lived at the service. One person did not speak but the staff did not engage with the person using touch, pictures, objects of reference or any other form of communication. The only time the staff spoke with this person throughout the day was in giving instructions such as telling the person to sit down or taking objects out of their hand. There was one exception to this when one member of staff asked the person if they wanted to join a game of throwing a ball. When people expressed themselves through their actions or by making noises the staff ignored them or attempted to contain them, for example by telling them not to do that or to do something different. The staff showed no awareness of people's individual interests or their perception of a situation, for example telling one person to ''Clap for [the prime minister of the United Kingdom].'' because the staff were watching and discussing a television programme about the general election. The person had shown no interest in this programme and information within their care records indicated they did not have the capacity to understand this and were not interested in this. This lack of understanding and awareness from the staff showed that they were not competent or skilled in being able to meet people's needs.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not always being met. The staff prepared meals for people at the service. There was a basic record of people's individual nutritional needs and the staff recorded the meals they had provided to each person daily. One person was at nutritional risk and was given additional food supplements in the form of juice and milkshakes. They had low appetite and records of the meals they had eaten showed limited variety and little nutritional balance. The person had not been weighed since December 2016 and whilst the staff recorded a general record of the meal offered, they did not record accurate amounts of how much the person had eaten or drunk. There was no evidence of a referral to a

dietitian or information about recent consultation with a dietitian. The staff were aware of some of the risks associated with low weight. But there was not a record of this. The staff had not carried out regular assessments of the person's nutritional needs and there was not a clear care plan to describe how the person should be cared for in relation to this.

Another person had a higher than average BMI (body mass index). At our previous inspection their relative had told us they were concerned the person had gained weight since moving to the service. We observed that during our inspection the person ate three different packets of crisps and a cup cake. At 1pm when the two other people were served lunch the person was not given any lunch. We heard one member of staff say to another, ''[Person] will not want any lunch because [they] have a cake and some crisps.'' The staff showed no awareness of the importance of meeting people's individual nutritional needs. There were no assessments or care plans to describe how these should be met and with the exception of recording the meals offered, there was no monitoring of how much and what people ate to make sure they received the right balance of food. This placed people at risk.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was not always suitably maintained to meet the needs of people who lived there. For example, the communal shower was missing a rose so that water came out of the shower in a single jet.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service manager told us that applications for DoLS had been made for all three people who lived at the service. They said that one person's DoLS had been authorised but they were still waiting for the paperwork from the approving authority. They told us that one person had been assessed by the authority in March 2017 and they were waiting for the outcome of this assessment. They told us the third person's application for a DoLS had been sent to the authority in December 2016 but that the authority had not received this, so a new application was being sent shortly after our inspection visit.

The provider had created health action plans for each person since the last inspection. There was evidence of health care appointments for people, including visiting district nurses, doctor appointments, podiatry and dentist appointments. Information from the healthcare appointments had been recorded. During the inspection one person was supported to attend an appointment. The staff member supporting them had a good understanding of the outcome of the appointment and the next actions needed. We saw evidence that the staff took appropriate action when someone became unwell, for example arranging a doctor's appointment and contacting the community nursing team.

Requires Improvement

Is the service caring?

Our findings

At the last inspection of the service we received feedback from three relatives of people who lived at the service. They told us the staff were kind, polite and caring towards people. People who lived at the service could not tell us what they thought about this. We spoke with one relative at the inspection of 25 April 2017 and they told us the staff were kind.

Throughout the day we observed how people were being supported and the way in which the staff interacted with them. This included a period of time dedicated to specific observation of care and support. The staff were generally kind and they were not rude to people. However, the majority of interactions with two people were task based or were instructions. Most of the time the staff did not speak or interact with people at all. When more than one staff member was in the room they tended to speak with each other about non-work based things. The staff spent some of their time watching the television, which was on for the duration of the inspection. None of the people who lived at the home showed any interest in the television throughout the day. However, two people were told to, ''Come and watch the nice film'', ''Look at the television'', ''Come and sit down and watch the television'' and ''Watch the nice movie show'' at various different times by the staff on duty.

The staff demonstrated a lack of understanding and empathy towards the people who they were supporting. One person could not speak English as a first language. The provider employed one member of staff who spoke the person's first language. We observed the member of staff using this and English to communicate with the person. There was a list of key words the person spoke in their care record along with the English translation and phonetic spelling so that staff who could not speak the person's first language could attempt some basic communication in their language. None of the English speaking staff spoke with the person using words from their own language throughout our visit and for the majority of the time did not speak with the person at all. At times, the person attempted to communicate with the staff asking them questions or saying words in English and their own language. With the exception of the member of staff who spoke the person's language, none of the staff attempted to understand what the person was saying. For example, at one point a member of staff repeated the word the person had said and then said, ''What? I don't know what you are saying to me.'' They then ignored the person.

One person did not use verbal communication however they did communicate through touch, making noises and expressed themselves with objects they picked up and showed the staff. When the person picked up objects other than their own belongings the staff took these off the person. For example, when the person picked up the television remote control a member of staff took this off them. They then spoke with us saying, ''I don't know what [person] wants to watch.'' They said to the person, ''Come and watch the nice show.'' The staff member did not change the channel on the television and did not offer any other activity or support for this person.

At 1pm a staff member asked if we would like a cup of tea. One person who lived at the home said, ''Tea?'' and indicated that they wanted a cup of tea. The staff member told them they needed to wait until 3pm to have a cup of tea. The person repeatedly asked for tea and the member of staff told them, ''You have had

two glasses of juice and one glass of water you need to wait until 3pm to have a cup of tea.'' We heard the person asking other staff for a cup of tea later on, the other member of staff told the person they would need to wait until 3pm. We looked at the care records for this person. There was no indication that their drinks should be restricted and no clear medical reason why this would be the case. Therefore, the staff were imposing a restriction which had not been agreed. In addition they did not offer the person any other explanation for their decision, offer an alternative drink or engage the person in another activity to support them to focus on something else. The staff team collaborated to stop this person having their requested drink.

The staff did not always use respectful or appropriate language. One member of staff told a person they were a ''good girl.'' In another incident, one person was leaving the bathroom after using the toilet. A staff member stopped them saying, ''No no no'' and then telling the person to wash their hands and face.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who lived at the service remained in their room for the whole day. This was normal for them. The staff spent some time sitting with the person talking with them. The person appeared to enjoy having the company of staff and appeared happy and relaxed when the staff were with them.

Inadequate

Is the service responsive?

Our findings

At the inspection of 16 January 2017 we found that people were not always supported in a way which met their needs and reflected their preferences. The provider sent us an action plan telling us they would make the necessary improvements by March 2017.

At the inspection of 25 April 2017 we found that no improvements had been made. One person who lived at the service was under the age of 30 and one person was under the age of 40. However, the way in which they spent their time did not reflect their individual needs and was not age appropriate. One person was not supported to access the community or take part in activities outside of the home; the other person spent a small amount of time accessing the community. During our inspection visit one person was supported to attend a medical appointment. This was the only time during the day during which they left the building. The other person was at home all day.

We looked at the records of care provided for the month of April 2017. We found that one person had not left the home at all during the month. The staff confirmed that they did not take the person into the community. They told us the reason for this was because the person had epilepsy and they would be at risk of harm if they had a seizure when out of the home. Whilst there is a risk of someone with epilepsy having a seizure, this should not restrict their access to community activities. In addition, we noted that all of the person's recorded seizures in February, March and April 2017 had occurred at night. The person's needs assessment, which had been completed in February 2017 under a section entitled, ''My short/medium term goals and aspirations'' stated, ''I would like to be given more choices on outdoor activities as my behaviour improves and I am – and also to be aware of my new community.'' The person's risk assessment also dated February 2017 stated, ''I like going out to the shops and open spaces however my behaviour makes it difficult for me to go to the shops and sometimes go to the community.'' The risk assessment went on to describe some of the incidents which might occur in the community and a list of hazard controls for dealing with these. However, the person had not been given the opportunity to access the community at all. We noted that the staff had not completed any records to indicate the person had presented behaviour that challenged or been aggressive towards others during 2017 therefore it was not clear why this person was being restricted from leaving the service.

We also noted that whilst the risk assessment and needs assessment for this person described incidents which might be challenging, such as a lack of road safety awareness, they did not describe any type of activity which the person may enjoy or be appropriate for them outside of the service. The person's relative told us that where the person lived previously they went on outings most days.

Records for the month of April 2017 indicated that the other younger adult had been to the local shops four times, been to a local park twice and visited their family three times. There were no other recorded activities outside of the service.

The activities provided within the service for these two people were minimal. During our inspection visit one person was not supported to engage in any activity for the whole day, with the exception of a visit from a

family member which lasted 45 minutes. The person spent their time walking around the home, holding and picking up objects. The staff did not have any sustained engagement with this person and apart from two toys they held for some of the time they did not have access to other sensory items or toys to hold or play with. On several occasions the person picked up staff paperwork and items such as the remote control for the television. The staff removed these from the person without offering an alternative. Furthermore, the records of care provided for the month of April 2017 described a similar pattern of little stimulating activity. For example, records in the activity section of the daily logs for this person for the two weeks preceding our inspection visit were, 12 April – ''[Person] was just pacing around the unit touching items'', 13 April – ''8.50 – [person] was in and out of [their] room playing with toys and staring at [self] in the mirror'', 14 April – ''Relaxing in [their] room with [their] toys, family visit, chatting with family'', 15 April – ''Morning personal care watching TV, walking in the garden, playing with toys, evening personal care'', 16 April – ''Morning personal care, watching TV, walking in [their] room and lounge, playing with toys, evening personal care'', 17 April – ''Morning personal care, watching TV, walking in the garden, chatting with family, evening personal care, watching TV'', 18 April – ''12pm chores, watching TV, assisted with lunch'', 19 April – ''[Person] spent most of [their] time between the lounge and [their] room touching things and playing with [their] toys'', 20 April – ''[Person] was just moving around touching things and playing with [their] toys, 21 April – ''4pm evening personal care, watching TV, walking in [their] room'', 22 April – ''Morning personal care, watching TV, walking into the garden with staff and other service user, evening personal care, playing with toys'', 23 April – ''[Person] spent most of [their] time moving between [their] room and lounge (unable to read entry) and playing with toys'' and 24 April – ''Morning personal care, watching TV, playing with toys, playing with dominoes with other service user.''

There was no recorded plan of leisure activities, education or engagement for this person. The only reference to planned activities was within the person's needs assessment dated February 2017 which under the section ''meaningful activities/my interests'' stated, ''I like to play with puzzles and picture cards. I enjoy laying on my bed. I enjoy my own space and I'm more relaxed with the company of staff being with me. I enjoy looking at my reflection in mirrors and glass. I find listening to music and watching TV entertaining and relaxing. I like being in the kitchen when food is being prepared I'll go to my cupboard and take out my snacks. When the weather is good and I am in a good mood I'll go and wander around in the front garden with the assistance of staff.'' The reference to the person enjoying being in the kitchen when food was being prepared was contradicted by the statement in the ''further action required'' section of the person's risk assessment which said, ''Kitchen door must be locked when in use.''

The other younger person also spent most of their time walking around the service or sitting in different seats during our inspection. They attended a medical appointment with staff and were out of the house for 35 minutes. At one point a member of staff initiated a game of throwing a ball with this person. They told us the person enjoyed this activity and we observed they appeared to enjoy this. However, the total activity lasted from 12.20pm until 12.28pm and was interrupted for one minute when the staff member left the room and for another minute when another person took the ball out of the room. This person was in the kitchen whilst the staff prepared their lunch and they had some involvement in this preparation. The person spent some time following the staff around the home, although with only a few exceptions, the staff showed no acknowledgement of the person. The person did not participate in any other activity with the exception of eating lunch from our arrival at 9.30am until our departure at just after 3pm. The records of activities for this person for the month of April 2017 indicated this was typical of a normal day for the person.

The third person was in their 90s. They were physically frail and spent the majority of their time in their bedroom. The staff spent some time sitting with the person and talking. The staff told us the person enjoyed listening to the radio and we noted this was left on for them the whole time. Records of their activities showed the only variation to spending time in their room with either the radio on or talking with staff was

occasionally going into the lounge to watch television and weekly visits from a relative. The person had dementia but there was no evidence the provider or staff had referred to good practice guidelines for providing care and support to people who was living with the experience of dementia. Their environment, care provided and engagement in activities did not reflect any of the nationally recognised guidance on providing care and support to older people or people with dementia.

The planned care for people was not always clear. The needs assessments for each person included one and a half pages of standard text referring to how care staff should meet a hierarchy of needs. However, there was no reflection of this in the care planned or delivered for each individual and the service was only meeting basic needs. The risk assessment for one person stated, ''Staff to follow various behavioural guidelines and strategies devised to help manage or reduce the incidence of identified risks.'' There were no guidelines in respect of this created by the provider. The person's file included some information from others, such as guidelines about how to support the person when preparing meals. These had been devised by the local authority. These were not incorporated into the documents for the person entitled, ''Needs assessment'' and ''risk assessment.'' There was no additional support or care plan for this person. In addition, the guidelines were not followed on the day of our visit. They specifically referred to the use of objects of reference and where the person should eat their lunch. On the day of our visit the staff did not use any objects of reference or follow any part of these guidelines. In addition, the person was not offered lunch and the only food offered to this person for the duration of our visit was three packets of crisps, a cup cake and a tangerine. The person's care file also included other guidelines from the local authority challenging behaviour team written in June 2016. Information from these was not incorporated into the person's needs assessment.

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an appropriate procedure for making complaints. Relatives of people who lived at the home said they knew who to raise a complaint with when we spoke with them in January 2017.

Inadequate

Is the service well-led?

Our findings

At the inspection of 16 January 2017 we found that the culture of the service was not open, transparent or inclusive. We also found the staff carried out audits and checks on different aspects of the service. However, the provider failed to have systems in place to assess, monitor and improve the quality and safety of the service.

At the inspection of 25 April 2017 the staff on duty told us they felt supported by the service manager. They said that the service manager visited the home regularly and was on call whenever they needed. They also told us that they had opportunities to meet with the service manager. One member of staff told us, ''If there are problems with the building we tell [the service manager] and [they] arrange for someone to fix this.'' One member of staff told us, ''I think we are doing a good job. The manager is on call if we need [them].'' The relative who we spoke with at both inspections told us that, ''Things are much the same, I do not see a lot of the manager.'' The staff told us they communicated well with each other. However, on the day of our inspection one member of staff was due to leave at 9am to be replaced by another member of staff. At 9.30am they told us this member of staff was delayed on the motorway. The member of staff did not arrive for work whilst we were at the service and another member of staff said that the absence had been prearranged the previous day. The member of staff who had been due to leave, but remained at the service, and was still there when we left, was under the impression the replacement staff would arrive at any time. No additional cover had been arranged for this staff absence.

The provider had not taken enough action to meet the requirements and warning notice which we had issued following the inspection of 16 January 2017. People living at the service were at risk and these risks had not been mitigated. For example, the provider had not taken enough action to ensure people were protected in event of a fire at the service. At the last inspection we identified that one person was being unlawfully restrained by the staff and that people were being unlawfully restricted. This was still taking place. The staff were working long hours without sufficient breaks, placing people at further risk. People's needs were not planned for and were not being met.

In addition to this, we found that records were not appropriately maintained. Staff recruitment, training and support records for six members of staff who worked at the service were not available. Care files for people who lived at the service did not contain essential information such as PEEPs. The risk assessments and needs assessments for people could not initially be located by the staff on duty and had to be inserted into people's care files once they were located. The staff rota was absent from the service. Records of fire checks and fire drills were not present at the service. Needs assessments, which had been signed by the current service manager as the author, included out of date information, such as reference to the name of the previous registered manager. Some forms within people's care files had not been completed or dated.

There was a risk because incidents were recorded on out of date forms. For example, the staff had recorded an incident which took place on 1 February 2017 where a person threw boiling water, putting themselves and staff at risk. The staff had used a form produced by a previous regulator for the recording of incidents under legislation which is no longer in force. The form advised the staff to send the notification to an office

address of the previous regulator which has not been used since 2008. It was not a legal requirement that this particular type of incident be reported to the Care Quality Commission (CQC). However, if the staff continued to use these out of date forms there was a risk that they would not know the correct procedures for notifying CQC.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We judged the risks relating to safety and staffing working hours as extremely serious and we contacted the provider to ask for assurances that they would take immediate action in response to these. The provider wrote to us telling us they would take action by 15 May 2017.

The provider had written and updated policies and procedures for the service and these were accessible and available for the staff to view.

At the inspection of 16 January 2017 we found that the provider had not always notified the Care Quality Commission of significant events. The provider sent us an action plan stating they would make the necessary improvements by February 2017.

At the inspection of 25 April 2017 we could not judge whether the provider had complied with this as there had been no incidents of serious injury that would need to be notified to the Care Quality Commission.

The Care Quality Commission (CQC) awards rating for the performance of registered services. The law requires providers to display this rating conspicuously and legibly at each location delivering a regulated service and on their website. The provider had not displayed their most recent performance rating at the location. The provider did not have a website.

The service manager told us that they had placed the inspection rating on display but said that the staff must have removed the notice and they did not know why. They showed us a copy of a letter they said had been sent to all relatives and staff to accompany a summary of the inspection report from 16 January 2017. The service manager agreed to ensure the rating was displayed again.

We asked the staff if they were aware of the findings from the most recent inspection report. They said that they had discussed this at the team meeting. However, they were not clear on the requirements which had been made and one member of staff said that the service manager had told them that we had found medicine administration records were incomplete. This was not a finding from the inspection of 16 January 2017 and had not formed one of the requirements we made. The wording in the report from this visit had included the statement, ''Medicine administration records were completed accurately and the staff counted and checked medicine stocks at each changeover of staff.'' However we saw the minutes of the team meeting held in March 2017 referred to the inspection findings stating that, ''[Medicine administration record] sheets were not filled in properly.'' Other reference to the inspection findings in the team meeting stated, ''CQC complained about the medication storage position. There were gaps in the log books and that the files were not up to date.'' With the exception of reference to requirements around staffing, there was no other reference to other breaches identified or to the seriousness of some of the risks we had previously identified. The information about staff working hours had been incorrectly communicated to the staff with the meeting minutes stating, ''[The service manager] informed staff that it is a requirement from CQC that staff will no longer do two days in a row together.'' The requirement regarding the deployment of staff made no reference to staff working two days in a row. There was no other explanation about why we had issued a requirement relating to the deployment of staff or the risks to people living at the service being supported by

staff who had worked excessively long hours. Therefore, the provider had not addressed this concern and people were still at risk.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person did not ensure that the nutrition and hydration needs of service users were met. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had not ensures that all premises and equipment used by the service provider was clean. Regulation 15(1)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure that the care and treatment of service users were appropriate, met their needs and reflected their preferences. Regulation 9 (3) (b) The registered person had not always carried out an assessment of the needs and preferences of service users or designed care to ensure these needs were met. Regulation 9 (3)(a)

The enforcement action we took:

We have issued a Notice of Proposal to vary the condition which specifies the locations the provider is authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so they are no longer authorised to carry on from Clover Residents - 2 Dorchester Drive, 2 Dorchester Drive, Bedfont, Feltham, Middlesex, TW14 8HP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had not ensures that service users were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We have issued a Notice of Proposal to vary the condition which specifies the locations the provider is authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so they are no longer authorised to carry on from Clover Residents - 2 Dorchester Drive, 2 Dorchester Drive, Bedfont, Feltham, Middlesex, TW14 8HP

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment The registered person did not ensure that care and treatment was provided in a safe way to service users because they had not: -assessed the risks to the health and safety of service users Reg 12 (2) (a) - done all that is reasonably practical to mitigate risks to service users Reg 12 (2) (b)

The enforcement action we took:

We have issued a Notice of Proposal to vary the condition which specifies the locations the provider is authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so they are no longer authorised to carry on from Clover Residents - 2 Dorchester Drive, 2 Dorchester Drive, Bedfont, Feltham, Middlesex, TW14 8HP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not safeguard service users from abuse and improper treatment Reg 13 (1) Service users were deprived of their liberty without lawful authorisation Reg 13 (5) Systems and processes were not operated effectively to prevent or investigate abuse. Reg 13 (2)

The enforcement action we took:

We have issued a Notice of Proposal to vary the condition which specifies the locations the provider is authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so they are no longer authorised to carry on from Clover Residents - 2 Dorchester Drive, 2 Dorchester Drive, Bedfont, Feltham, Middlesex, TW14 8HP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not assess, monitor and

	improve the quality and safety of the service. Regulation 17(2)(a) The registered person did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(2)(b) The registered person did not maintain securely record as necessary in relation to persons employed in carrying on the regulated activity. Regulation 17(2)(d)(i) Schedule 3

The enforcement action we took:

We have issued a Notice of Proposal to vary the condition which specifies the locations the provider is authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so they are no longer authorised to carry on from Clover Residents - 2 Dorchester Drive, 2 Dorchester Drive, Bedfont, Feltham, Middlesex, TW14 8HP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not deployed sufficient numbers of competent or skilled staff. Regulation 18(1)

The enforcement action we took:

We have issued a Notice of Proposal to vary the condition which specifies the locations the provider is authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so they are no longer authorised to carry on from Clover Residents - 2 Dorchester Drive, 2 Dorchester Drive, Bedfont, Feltham, Middlesex, TW14 8HP