Outward

Church Lane

Inspection report

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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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

The inspection was unannounced and we visited on 8 and 9 July 2014. At our last inspection on 1 May 2013 we checked to see if the provider had made improvements in maintaining the dignity of people at the service. The service had made the improvements we required.

Church Lane is registered for six people and at the time of our visit was providing care to five men aged between 19 and 25 with a learning disability and/or autism spectrum disorder. The home has a sensory room and a garden. A registered manager was in post but had not been at the service for 10 months as they were on secondment. The

Summary of findings

CQC were initially informed about the three month absence but not for the remaining seven months. At the time of our inspection the deputy manager was acting as the lead manager. The deputy was supported by the area manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At this inspection we found that people's privacy and dignity was not being maintained.

People were at risk of unsafe care as staff had not been given the training to keep their skills and knowledge up to date. Staff told us they were concerned about the safety of residents and wanted guidance on how best to keep them safe. Staff did not know how to manage behaviour that challenged the service and had not received up to date training about how to do this safely. We reviewed incidents where people had been injured at the service, but no notifications to the local authority or the CQC had been made. Some relatives wanted their family members to leave the service due to concerns around safety.

The acting manager demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards however staff did not understand the implications. Staff were not aware of when they would be expected to request a best interests meeting or why they may need to deprive someone of their liberty. It was recorded in a care plan how one person's finances were managed by the Court of Protection, but we could find no official paperwork in their file to confirm this. The acting manager told us that the person came to the service with this information in place, but the evidence was not recorded and it was not possible to see if this still was valid.

Medicine procedures were not always followed. This resulted in medicines signed as administered before they had been taken. There were also unexplained gaps in recording of medicine on the MAR chart.

People's needs were initially assessed, but care plans and risk assessments were not up to date to reflect current care practice. Staff were not always following what was stated or sometimes they were not aware of what was in the care plan so effective care was not being given.

A person who was at risk of malnutrition had not been re-reviewed by the dietician after it had initially been sought.

Some staff spent time with people trying to interact with symbols and Makaton (a language programme that uses signs and symbols to help people communicate) and we observed positive responses from people when this took place. However, not everyone at the service experienced good interactions.

Communication with relatives was not consistent. Some relatives told us they received good communication by email and others said they always had to contact the service for information updates which made them feel like they were being "a nuisance."

Staff team meetings took place, but not at regular intervals. Staff said they attended when they could and found them helpful. We found with team meetings and supervisions that staff found them helpful, but wanted to receive more feedback about concerns they had raised about people at the service and how to care for them. There was no audit system for records, in particular the checking of hand over sheets, food diaries or medicine records.

Staff were observed to be caring and spoke to people in a kind manner. Comments received from families were positive about staff being caring for their relatives.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report. Where there has been a more serious breach of regulation we will make sure action is taken. We will report on this when it is complete.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People had been injured by other people at the service. People were at risk of further injury as some staff were not trained in how to manage behaviour that challenged. Staff were often attending to people with complex needs, which left other people at risk of harm.

Staff knew how to report suspected abuse but the service did not always notify outside agencies as required.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not understood by care staff but the acting manager was able to demonstrate understanding, when it was needed.

Is the service effective?

Inadequate

The service was not effective. Care plans and risk assessments were not up to date and contained information that was contradictory. This meant that staff did not have the information they needed to meet people's needs effectively.

People were not always given a choice of meals and people's nutritional needs were not always appropriately assessed or met.

People were supported to maintain good health and to access health care services and professionals when they needed them.

Is the service caring?

Requires Improvement

The service was not always caring. Some staff were caring and spent the time engaging meaningfully with people at the service.

The service did not always maintain the privacy and dignity of some people, as staff did not take appropriate action to ensure people were suitably clothed.

Relatives thought the acting manager was caring and that some staff were caring and others more task focused.

Is the service responsive?

Requires Improvement

The service was not always responsive. Staff identified where further action was needed, but did not always follow through to ensure care was reassessed and provided and people's needs met.

Only one person had an up to date activity schedule that was followed and another person attended college. Everyone else at the service was not supported by the service to find activities that they wanted to do.

People and their relatives knew how to make a complaint. A complaints process was in place.

Summary of findings

Is the service well-led?

Inadequate

The service was not well-led. We found shortfalls that had not been identified and addressed by the management team.

Staff commented that they wanted feedback, which was not forthcoming, on issues they had raised about people at the service and how to support them better.

There was no audit system for records, in particular the checking of hand over sheets, food diaries or medicine records.

Church Lane

Detailed findings

Background to this inspection

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience who undertook this inspection had experience of learning disabilities and autistic spectrum conditions.

Before the inspection we reviewed the information we held about the service, which included the provider information return (PIR) and notifications. The PIR is a report that providers send to us giving information about the service, how they met people's needs and any improvements they are planning to make. We also contacted a commissioner of the service to obtain their views.

We spoke to seven members of staff at the service. We also spoke to the acting manager and area manager. After the inspection we spoke to five relatives. People who used the service were unable to verbally communicate with us so we observed care and interactions between them and the staff.

We reviewed two people's care records. This included their support plans, risk assessments, daily log books, weight monitoring charts and activity plans. We also reviewed staff records, which included training, supervision and appraisal records and observed care and support in communal areas.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

Some aspects of the service were not safe. Staff could tell us how they would identify abuse, if they suspected it, and we saw evidence that where a concern had been identified staff had raised this with the manager or had whistle blown. The service had safeguarding and whistleblowing policies and staff knew where to locate these. However, we saw some recorded incidents relating to safeguarding concerns where a safeguarding referral to the relevant local authority or a notification to the Care Quality Commission had not been made as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of Other Incidents.

Staff were concerned about people's safety and said that some people were more vulnerable than others at the service, as they were very quiet. For example, some people displayed behaviour that challenged, which left other people in the service at risk of being injured. Staff had not received up to date training in how to manage behaviour that challenged and we read incidents where staff had been injured. When we looked at the training records 5 staff members out of 16 had not completed training on how to manage behaviour that challenged. The provider told us after the inspection further training was made available to staff. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A relative told us they had been "grabbed" by people at the service and said when it happened staff did not know what to do apart from saying to the person using the service "don't do that." This was not in accordance with the information leaflet given to visitors that described the service and the type of behaviour they may see at Church Lane. It said that staff would guide visitors about what to do if incidents occurred. This had not happened on that occasion and placed people using the service at risk of injury as guidelines on the leaflet were not adhered to. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed an evening medicine round and had concerns that the correct procedure for administering medicines was not followed. Staff recorded that medicines had been administered before they had completed the task. We raised this issue with the staff in question and the acting manager. We were informed that staff were told this practice was incorrect and not in line with the company's medicines procedures. We reviewed the medicines administration record (MAR) sheets and saw a recording error where the medicine for one person was missing from their blister pack, yet the MAR had not been completed. Staff did not know if the medicine had been taken or not, which was unsafe practice. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two relatives said they thought their family member was safe. Another relative told us they thought the behaviour of other people in the home meant their family member was not safe. A further relative said, "It's not safe for [my relative] there. I've done complaints. To be honest I don't know. I saw deep scratches on the back of [my relative's] neck. Another time [my relative] got trapped in the lift. Since that incident, I just want [them] out."

Care plans stated that all five people in the service should have either received one to one care or two to one care from a support worker. On the first day of the visit we found that on some occasions this need was not being met as staff had to attend to a person with higher level needs. A staff member said, "When this happens three staff have to attend, which means that the other residents are not receiving one to one care."

Incidents showed that there were occasions where people had been harmed by other people in the service at night. The service implemented measures where they would know if someone had left their room at night. This was also discussed at team meetings to ensure staff working at night were extra vigilant to maintain the safety of other residents. There were also incidents of people being injured by this person in the daytime. The service had a plan in place to reduce these instances and were working with the safeguarding authority to address these concerns

Staff were trained in the Mental Capacity Act 2005 (MCA) but some training was out of date. Two out of seven staff were not able to demonstrate knowledge of how or when they would use the MCA. At the service no one was subject to Deprivation of Liberty Safeguards (DoLS). The acting manager demonstrated an understanding of MCA and DoLS and gave an example of when a DoLS would be needed. MCA is a law which protects people who are unable to make decisions for themselves. DoLS can be applied for if people cannot be kept safe without restricting

Inadequate

Is the service safe?

their liberty. However, staff were not aware of when they should seek a DoLS authorisation or what it meant. For example, it was recorded in a care plan how one person's finances were managed by the Court of Protection, but we could find no official paperwork in their file to confirm this. The acting manager told us that the person came to the service with this information in place. However, the evidence was not recorded and it was not possible to see if this still was valid. Therefore we could not be assured that the provider was acting with the person's valid consent or in accordance with the MCA if this was not possible. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

We reviewed two people's care plans and found they contained a pen picture, which gave details about how a person read symbols and what they liked to do, a photo, specific risk assessments, support plan, hospital passport and "my community" which informed staff of the signals someone would display if they wanted to go out shopping, for example.

However the care plans we viewed were inconsistent and contained information that was not up to date. For example, when staff were describing care that was given to people, they explained how someone no longer used a communication board, yet it was still documented in their care plan that this occurred. We also noted an issue where it stated a person would signal when to go shopping and that they "would pick up items" yet later in the plan it stated they were not involved in shopping. This posed a risk as new staff were informed to read care plans so that they could get to know people at the service, but the information was not correct or current and meant effective care may not be given.

We noted that not all staff were aware of people who were at risk of malnutrition. In care plans this was not clearly identified. For example, in one risk assessment one person was identified as being at low risk of malnutrition and in another assessment they were recorded as medium risk. We checked the file to see what actions the service should be taking. We saw that a dietician was involved in 2012 and they had set out specific guidelines for staff to follow, in particular the amount and type of food to be given. However, we could not see evidence that the guidelines had been followed in the log books and food diary. Furthermore, we noted that there was no follow up with the dietician to determine whether their involvement was still needed or not. We were told by the acting manager that at present, weight monitoring of the person took place This was a breach of Regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service maintained food diaries for people. In some instances where people had not eaten sufficient amounts on more than one occasion over a few days, we did not see any evidence that a healthcare professional had been contacted for further advice or follow up. This posed a risk for people, as staff were not able to identify where action should have been sought. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted in one care plan how someone was to be offered a choice of two meals. We did not see this happening and when staff were asked if they were aware of this, they were not. The acting manager told us that they chose the menu which did not show how people were exercising their preferences. We did not see people being asked what they wanted through communication methods that helped engage them. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In relation to choice of food we did not observe staff asking people what they wanted for lunch or dinner, instead food was placed in front of them. However, staff told us that some people in the service would go and pick what they wanted for breakfast, for example cereal or toast. Staff told us if someone pushed the food away they would make something else for them. However, we observed someone pick at their food at lunchtime and staff did not offer an alternative food option. At our previous inspection in May 2013 the service was using pictures of meals, but we did not see these being used. There was a written menu but this was not in a pictorial format to encourage choice and to determine whether people actually wanted to eat what was on offer. This meant that people were not always provided food that they wanted. A relative said, "They could do more to offer different food to [my relative]."

We observed two mealtimes and saw that staff were helping those who needed support with eating and were not rushing people. The service had worked with a speech and language therapist and obtained guidelines in relation to supporting individuals with their meals.

Most of the staff were seen to be supportive and knew how to look after people's needs. For example, we saw staff interacting with people by using drawings and Makaton signs. However, we were told that not all staff were using people's specific communication books with pictures. In one example, staff told us they previously used pictures to prompt people to use the toilet and this had produced positive results. However, this practice stopped and staff said they were not sure why and the previous negative

Is the service effective?

behaviour that had somewhat reduced had come back. This meant that some people at the service were not moving forward or receiving effective care as staff were not consistently maintaining positive actions.

Staff had worked with a speech and language therapist to support one person around language. Staff were using objects of reference in a positive way, which helped the person to understand what was happening in their environment. Objects of reference are objects which have meaning assigned to them. For example, the service would show people their college ID so that they would know they were going to college.

Staff told us they were given an induction when they first started working at the service. After the inspection evidence was sent to confirm staff had completed an induction and one member of staff said, "Yes, I received an induction." Induction training included understanding where to find equipment in the house, mandatory training and emergency procedures to get people out of the home in the event of a fire.

We observed an induction for an agency member of staff on the second day of our visit. An experienced member of staff showed the new staff member around the service and introduced them to people living there. Following this the agency member of staff was told to spend the day observing care and help with food preparation and completing log books. However, we noted that information that was used in the induction was out of date or could not be found, in particular reference to the use of crisis prevention intervention (training on how to manage disruptive or assaultive behaviour). As other permanent staff had not received current training on this topic and did not know what to do, this information was incorrect. We informed the acting manager about this who told us this would be removed.

Staff told us they had not been given sufficient guidance or current advice on how to manage behaviour that challenged before or after the incident. One staff member said, "I'm not sure what to do" and "There are no guidelines." An agency member of staff supporting someone with complex needs said, "The manager said stand back, don't get too close. If [person] starts to pull your shirt, don't try to draw back." This advice was not documented anywhere in a care plan to inform staff so that risks posed by this person's behaviour could be managed safely.

We noted that 13 permanent staff out of 16 had not completed autism specific training and that four permanent staff had out of date training in this area. After the inspection we were sent information stating that this training had been booked. One relative said, "I don't even know if the staff have specialist autism training to look after [my relative]." Further to this we were told that agency staff were not given the same training that permanent staff received. This put people at risk of receiving care that did not take account of their specific needs. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they received supervision with the acting manager approximately every six weeks and we saw evidence to confirm this.

People were seen by the optician and this was done at the service if they were unable, or did not like leaving the home which showed consideration to people's individual needs. Other health appointments were made to see the GP and dentist as necessary to help maintain people's health.

Requires Improvement

Is the service caring?

Our findings

The service did not always maintain the privacy and dignity of some people, as staff did not take appropriate action to ensure people were suitably clothed. This was raised as a concern with the acting manager as the accommodation was shared. We also viewed instances where people were undressing in the communal areas and staff did not know what to do and did not encourage people to go to their bedroom where they could have some privacy. We raised this with the acting manager and were told they would address this. This behaviour deterred people's relatives visiting the service to see their family members. One relative said, "They are always naked when I visit." Another relative said "I don't visit anymore as I have a young granddaughter and [person] is always naked." This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were observed to be caring and they spoke to people in a kind manner. One member of staff said, "If I see [person] is upset I will try and comfort them or they may want a hug." Another member of staff said, "I will give [person] space if they want to be left alone but will let senior staff know." A member of staff also gave examples of how they performed intensive interaction with the people they worked with. One staff member said, "I'll put the radio on and me and [person] will dance and they copy what I'm doing."

However, on the first day of our inspection staff were observed to be reactionary to incidents at the service and did not respond appropriately to these. For example staff were unaware of how to respond to two people who were screaming at each other and we were told it was something they did to "wind each other up." We observed that the people were distressed. On the second day of our visit we observed other staff spending more time engaged in activities with people. People at the service were unable to tell us if they thought staff were caring. However, we observed people at ease with staff at the service and saw they would often go to a particular staff member and sit with them and hold their hand showing they were comfortable with them.

We observed an agency staff member tell someone who used the service to go to their room as they entered a communal area without reason. We raised this immediately with the acting manager. The acting manager said they had addressed this issue with the staff member in question as poor practice as people were free to walk in communal areas.

People had individual care plans, which informed staff about what they liked to do, their life history and their needs. People's religious beliefs were stated in their care plans and we saw that some people were supported to attend religious services each week. Cultural needs were respected in relation to food and staff were able to demonstrate that they cooked foods specific to people's cultural and religious beliefs.

Relatives said that the acting manager was caring. One relative said, "The staff are very friendly and engaging." Another relative said, "There are some very good carers but I feel that some just come to do their duty and go home." One relative commented, "The carers are kind and caring, but it is sad that so many carers have come and gone." Another relative stated that they did not always know who was working with their family member as there were different staff working each time they visited. The feedback from relatives indicated a lack of consistency and continuity of care which meant they were left unsure about how caring staff would be.

We observed staff knock on bathroom and bedroom doors before entering and asking people for permission for us to view their rooms when they showed us around the service. This demonstrated they respected people's private space. Staff explained how they maintained people's privacy and dignity while giving them personal care by ensuring curtains were drawn and doors were closed. Some people also enjoyed spending time alone in their bedrooms or wanted to be alone in the sensory room, and this was respected by staff.

We received mixed views about the service from the relatives we spoke with. One relative said they were contacted when there had been a change in their family member's care and another relative said, "I was contacted when [person's] medication was changed." One relative commented they were told about any upcoming trips and holidays. However, other relatives said they sometimes felt like they were "bothering" staff when they called to ask how their family member was, which sometimes put them off calling.

Requires Improvement

Is the service responsive?

Our findings

Activity plans were in each person's folder. However, some of them were out of date or not being followed. We saw one person who followed their activity plan and another person who attended college, but the rest of the people using the service did not have structured activities. For example, on the two days that we visited we observed one person who walked around the downstairs communal area and gardens with a DVD for the majority of the day. We did not see any engagement from staff to encourage additional activities. From the evidence viewed only a few activities were tried and new ones were not always explored with people. Most people enjoyed going on the bus, but we did not find people were undertaking meaningful activities of their choice. Two staff said, "There needs to be more varied activities for people here." We found that the people in the service who could express themselves through signing or by showing staff on electrical devices, were experiencing better outcomes in relation to activities. This meant that people were not always supported to participate in activities they liked. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We contacted a local commissioner before the inspection. They had visited the service in March 2014 to carry out a monitoring visit and expressed concerns that risk assessments were not completed fully and contained inaccurate information, which was duplicated. We noted that care plans and risk assessments had not been updated since the visit by monitoring officers.

We were told by management and staff that people's needs were identified through staff observations. These observations were further discussed at staff supervisions.

One member of staff explained how they had noticed that someone had a rash and said they informed the manager straight away. An appointment was made with the GP and the person was seen that same day. The staff member said, "I called the doctor as it could be something worse."

We saw that staff had identified boredom as a possible trigger for someone's behaviour. Staff were told they should take people out more often and we saw evidence that this was happening. In other instances where a change in behaviour had been identified staff were encouraged to record all incidents so that healthcare professionals could review the information. This was being done in most cases as we saw incident logs and daily records detailing what had happened during the day. But at times this had not happened which meant the service was not responding quickly to ensure people got the care needed. Staff were also encouraged to discuss all issues at staff handovers and document information in the handover folder. But, where food diaries needed to be kept there were sometimes gaps in the recording with no explanation. This posed a risk as the relevant professionals may not have had sufficient records to fully identify trends and suggest better ways of working with people using the service to protect their welfare and safety.

People who wanted to go out were supported by staff and there were no restrictions preventing people from doing this. People would indicate they wanted to go out by getting their shoes. We saw people were taken to collect their money and taken to local cafés and fast food restaurants as that is what they liked to do.

Relatives told us they knew how to make a complaint and where the complaint had gone to the service, it had been acknowledged in accordance with their policy and procedures and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

The registered manager had been away from the service on secondment for the past 10 months. The registered manager had notified the Care Quality Commission about this, but the planned absence of three months had been exceeded and we had not been kept up to date about the seven month extension. This was a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009. The deputy manager was leading the service with support from the area manager.

Although the deputy and area manager were working at the service we identified a number of shortfalls that had not been addressed and were having an impact on the people using the service. For example, care plans had not being updated since the local commissioner's visit and staff training was also not being monitored to ensure it was up to date. Staff had also said they wanted more experienced staff on each shift to support people with complex needs. Staff suggested that six or seven members of staff would be sufficient as opposed to four or five so when they needed to attend to a person with complex needs other people would not be on their own. Staff felt that the use of agency staff was difficult as they had to explain people's different needs all the time and this meant a lack of continuity of care for people.

There was no audit system for records, in particular the checking of hand over sheets, food diaries or medicine records. These records contained unexplained gaps or errors, which meant they were not being accurately maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives told us they could speak to the acting manager whenever they wanted, however some relatives said that management of the service needed to improve. Two relatives said, "When I tell the acting manager my concerns then something gets done about it." "[name] is a good manager we communicate by email as I can't always get there." One relative said, "the acting manager is caring, but does not have management ability and the previous manager was worse."

The service had regular communication meetings with one person's family. This proved to be a good outlet for relatives to voice their concerns about the quality of care their relative was receiving. A relative had told us they were not being contacted with updates about how care was going and as a result of the communication meetings staff were reminded of the importance to contact the relatives. However, we did not see the same format used for all relatives.

The acting manager told us a coffee morning for relatives was going to take place on the day of our inspection, however no relatives attended. We followed up with three relatives and one relative told us they did not know about the coffee morning and two others explained they either could not make it or wouldn't attend because of people being unclothed at the service.

Staff said that the acting manager was around and was always involved in care as much as they could be. Staff also said they could approach the acting manager with their concerns. We spoke to seven staff and one said that they did not feel supported in the care of people with very complex needs, which made them uncomfortable supporting people. One staff member said, "I tell the manager in supervision, but nothing is done about it."

Staff told us they attended team meetings, when they could. We saw evidence of meetings taking place, but these were not occurring at regular intervals. The team meetings gave staff details of feedback from external monitoring visits from the local authority, updated staff on behavioural changes in people and informed staff on important guidelines on how people should be supported. In the meeting from March 2014, after the commissioner's visit, we saw that the need for staff training updates had been discussed. We found that staff training was still not up to date and this had not been followed up during supervision sessions with staff.

Incidents at the service were recorded and the provider checked these to ensure that they had been recorded and responded to appropriately. Staff told us that when incidents had been reported they wanted feedback and guidance on what should be done in future to manage situations more effectively, however, this did not happen. This meant that staff were not getting the feedback they wanted, to help improve the quality of care for people at the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence The registered manager did not give notice in writing to the Commission of their continued proposed absence. Regulation 14(1)(b)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission without delay any abuse or allegation of abuse in relation to a service user. Regulation 18(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to care and treatment provided for them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure that service users were protected from the risks of inadequate nutrition and dehydration as they did not receive a choice of suitable food or adequate support for the purposes of enabling them to eat and drink. Regulation 14(1)(a)(c)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers The registered person had not made suitable arrangements to protect the health, welfare and safety of service users by working in cooperation with other to ensure appropriate care planning took place. Regulation 24(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure persons employed for purpose of carrying out regulated activity were appropriately supported; including receiving appropriate training. Regulation 23(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with unsafe use and management of medicines by making appropriate arrangements for the recording and safe administration of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not ensure there were suitable arrangements to ensure the privacy, dignity and independence of service users and that service users are enabled to make, or participate in making decisions relating to their care or treatment. Regulation 17(1)(a)(b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not protect service users who may be at risk from unsafe or inappropriate care by means of the effective operation of systems to regularly assess and monitor quality of the services provided or identify, assess and manage risks relating to health, welfare and safety of service users and other who may be at risk. 10(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Care Quality Commission of allegations of abuse in relation to people who use the service. Regulation 18-(2)-(e)

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user, (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.