Innova Care Limited

Poplars

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 29 April 2016. Inspections are generally unannounced but we telephoned this service the evening before to check that people using the service would be available to speak to us and could be informed ahead of our inspection what the purpose of our visit was.

The service provides accommodation for up to six people who may require nursing, have a mental health need and might have an additional learning disability and behaviours which can be challenging.

The service had a registered manager in post. 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 2008 and associated Regulations about how the service is run.

The service was last inspected in March 2013 and at the time was judged as compliant for the areas inspected. Since the last inspection our methodology has changed in line with changes to legislation and we now carry out comprehensive, ratings inspections. This was the first ratings inspection for this service. During this inspection we found:

There were enough staff on duty at all times to meet people's needs and they were sufficiently familiar with their roles.

There were systems in place to ensure people received their medicines as required and at the time prescribed. Audits were in place but not particularly robust. Medicines were administered by trained staff but we saw no evidence that nurses were assessed to ensure they remain competent and up to date with best practice.

Staff recruitment processes were in place but not particularly robust in terms of ensuring staff employed had the right skills, attributes and understanding of the needs of people using the service.

The risks to people's safety were managed but we felt staff did not always get the balance right between promoting people's independence and proportionate risk taking.

Staff were supported through an induction process and training but we were not assured that the training was sufficiently robust or provided around the needs of people using the service. The fact that some of the staff were registered nurses was not sufficient. Care staff had not received training around mental health, epilepsy or learning disability. Support for staff was in place but we could not see evidence of how staff were developed and how good practice in the service was promoted.

People were supported to eat and drink but this was managed by staff and there was insufficient opportunity for people to be involved in menu planning to ensure their dietary needs were met and they had

their food preferences. We saw at least one person whose weight was not closely monitored.

People's health care needs were met through a number of different professionals but we were unable to see from records how closely people's needs were monitored and if people always had regular access to all the health services they needed.

Staff spoken with did not have much understanding about the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and we did not see people being given meaningful choice. Applications had been made as required under Deprivation of Liberty Safeguards (DoLS) when it was considered to be in the person's best interest.

We observed staff working in a functional way and paying attention to rigid routines rather than supporting people in accordance with their wishes and preferences. People's independence was not sufficiently promoted and there was not enough consultation with people about their wishes.

Care plans were in place and kept under review but we could not see how care was individualised or how changes in people's needs were recognised and acted upon. This was not a progressive service which helped people reach their goals.

There was limited activity for people and we could not see from their records what people enjoyed or what incentives there were for people in terms of encouraging positive behaviours.

The service was not well led because there was limited engagement with people using the service outside assisting them with their day to day tasks. Staff were not supported to develop and to provide person centred care. There was poor quality monitoring to ensure the service was run in people's best interest and took into account people's experiences.

We found breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We have also made a number of recommendations which we feel would help the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were not fully mitigated and people were not encouraged to remain as independent as they could be.

Staffs knowledge of how to safeguard people in their care was poor.

Staff recruitment processes were in place but not sufficiently robust.

There were enough staff to meet the needs of people using the service.

Medicines were administered as required but there were no formal system to check on the competencies of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People using the service did not have much choice or autonomy particularly around meal times.

Staff received training and support but we could not be assured all staff were competent or had received up to date training.

People's health care needs were not always documented so we were not confident they had been met.

Staff had some understanding of MCA and DoLS but care practices were restrictive and inadequate choice was offered.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not promote people independence or dignity.

Care was task focused.

People were not adequately consulted about their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not get their needs met in a meaningful way or opportunities to participate in activity appropriate to their needs.

Care plans did not identify how staff should provide individualised care.

People were not adequately supported to raise concerns/feedback about the service.

Is the service well-led?

Requires Improvement

The service was not well led. There were ineffective systems in place to monitor the quality and effectiveness of the service and people were denied opportunity to live fulfilling lives.

There was little development of staff.

There was little community involvement.

Poplars

Detailed findings

Background to this inspection

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

The inspection took place on the 29 April 2016 and the provider was given a short period of notice, (less than 24 hours') of the inspection going ahead. This was because we wanted to be assured that people using the service would be available to talk to us.

The inspection was undertaken by one inspector and an expert by experience who is a person with personal experience of using or caring for someone who uses this type of care service.' Our expert had experience of mental health and learning disability services.

On the day of our inspection we sat in the lounge area and observed interactions between people. We spoke to people using the service and staff about the care and support people received. We spoke in private with three people living at the service, three care staff and two of the nurse's, one of whom showed us the medication. We looked at four care plans and other records relating to the management of the business.

Requires Improvement

Is the service safe?

Our findings

We spoke with staff about whistleblowing and safeguarding people in their care. Staff were not clear about how to report concerns although the manager told us staff were reminded on a regular basis and it was documented in a recent staff meeting that this had been discussed. The manager said staff had all received training but three of the staff we spoke with could not recollect receiving training in safeguarding, whistleblowing or Mental Capacity. All said they had no concerns about the service.

We noted there was no visible information in the service for people to refer to on how to raise a concern to the Local Authority safeguarding team, the information was available for staff but it was unclear how people using the service or their visitors might be aware of this.

We asked the manager about any raised safeguarding concerns about the service or from the service. He told us there had not been any with the exception of a recent concern about hospital admission during a person's recent stay. This was raised by the service and was not about the service.

The systems for the management of people's finances were not always clear or transparent and we have raised our concerns with the Local Authority. Staff were using people's money to reward/sanction positive and negative behaviours. We also noted that people were spending money as shown on financial transaction sheets on snack/biscuits/crisps which we would expect to be available in the home if people wished to eat them.

This was a breach in Regulation 13: Safeguarding service users from abuse and improper treatment.

Two out of the three people we spoke to told us they felt safe. One person said, "The doors are locked so no-one can get in" and another said, "My family member can visit me easily."

Whilst there two people made accusations one against members of staff and other people at the service and another person said another person had assaulted them. This information was dealt with by staff and during handover the information was recorded on the person's notes and handover sheet. However at the time of the alleged incident there were no witnesses and no observed injury to the person so the staff could not ascertain if the said incident occurred. These could be viewed as safeguarding concerns but were not reported as such. The manager told us no incident had occurred of late. We looked at the incident records which recorded a number of incidents mainly falls which had been reported and recorded and there was limited actions recorded to try and minimise the risks to people.

There were structures in place to ensure people's safety. People and staff told us that fire drills took place and staff spoken with had awareness of risks associated with people especially when out in the community. All three mentioned ethical care control and restraint (ECCR) training which focussed on restraint and how to diffuse tensions between individuals. Staff confirmed that restraint was seldom used saying, "The staffing level is good here, and we can diffuse arguments easily."

People's care needs were documented in their records but we did not feel there was a proportionate approach to risk taking. For example we found files of generic risk assessments which did not take into account people's individual needs. We observed care practices and saw people were restricted without necessary justification. For example chairs and tables were fixed and cups for juice were plastic. We were advised this was because they could be thrown causing people injury. Bottles of sauce were not put on the table because staff said people might use these excessively. Staff told us salt and pepper was automatically added to people's food.

One person had a number of falls without significant injury. These had been documented stating the person refused to wait for help so it was a risk they were choosing to take. This was not underpinned by an assessment of their capacity to take risks. However the reasons for their falls had not been looked at to see if they could be reduced and their declining mobility and increased age had not been taken into account.

One person was nursed in bed but there were no records within their room as to how often they should be turned to prevent skin damage. The person was not on a specific mattress designed to help prevent pressure areas. When we asked staff they gave us different information about how often they should turn this person. There was no record of how staff monitored this person's weight. They were not able to use conventional scales but there was no record either of staff recorded their body mass index which would give staff an indication of their malnutrition risk. We could not see how their needs were fully monitored as some assessments from other health care professionals had occurred a number of years ago and we were not clear if the person's needs had changed.

This was a breach of Regulation 9: Person centred care.

We looked at staff recruitment practices. Staff records included evidence of the staff's suitability to work in the care industry including a checkable work history, references both personal and professional, a criminal records check and proof of identification and address. The recruitment process was not however robust. We saw no evidence of the interview process to ensure staff employed had a good attitude and attributes relevant to their role. There were no copies of staff certificates relating to their professional qualifications.

We completed a medication audit at the service. Medication was administered by trained nurses who are required to keep their professional skills up to date. However when we asked the manager for evidence of the nurses training and development they were not able to provide this.

We asked about audits to ensure people received their medicines safely and saw that nurses completed a monthly stock audit counting all the tablets to ensure it tallied with the balance they said they should have in stock. We were unable to see any other audits, either by an external provider or checking that medication recording sheet were completed correctly or that creams/eye drops ect were in date and still relevant to people's needs.

We looked at people's individual records and could not see any guidance available for medication which was prescribed to be taken as needed. This was only available but on the office computer as were the medicine policies and procedures but was not easily available for staff at the point of care. In the medication records there was no information about the medicines people were taking, possible side effects or how people preferred to take their medicines. This meant that staff would not always be able to support people with the full details

The home only had one controlled medicine and this was appropriately recorded and countersigned in the controlled drugs register.

There was a homely remedies policy and people if taking medication regularly were written up for a regular prescription by their GP. No one at the service took their medicines independently not even creams and it was not clear if this had ever been assessed.

Medication was given as prescribed and there was clear times for medication administration and there was evidence medicines had been reviewed.

We noted the creams/bottles of medicines were signed with dates when opened to ensure staff knew when they were going out of date and required disposing.

Staffing levels were sufficient. Staffing levels were maintained across the day and we saw no fluctuation from the staffing rotas inspected. The manager told us there was always a qualified nurse on duty supported by three care staff. The manager and senior staff had time which was supernumerary on the rota to complete administrative tasks and covered the shift when required.

At night there were two waking night staff, one being a registered nurse. Staff we spoke with told us that some staff worked both days and nights and some staff worked long days. Most staff were part time and picked up overtime as required. This meant agency staff were not used at this service and people got continuity of care.

There was no dependency tool in place showing us how many hours support each person required and the justification for staff hours. The manager said people's needs had remained static. Staff told us that they were able to meet people's needs and the current allocation of staffing hours appeared generous. However at least one person required two to one support and another required two staff to accompany them out in the community. We saw that people did not always access the community on a regular basis.

We recommend that the service introduces a dependency tool to demonstrate how they assess and review people's needs and staff the service according to people's identified needs.

Requires Improvement

Is the service effective?

Our findings

We spoke with staff about their initial induction when they first started work. Staff told us they had spent time with the manager going through key areas of practice and becoming familiar with the home, people's needs and plans of care. They then completed a work book which covered common induction standards which was a national recognised induction covering everything which was needed for 'carers.' We saw examples of completed workbooks. Staff had a probationary period of three months.

The manager had completed a three day course in recognised behaviour techniques which taught staff about restraint as a last report but focussing mostly on de-escalating techniques and how to support people without causing injury.

Training was recorded on the computer and staff records did not show evidence of what courses they had undertaken before or since being at the home. There was variable uptake of the ECCR training with some staff having completed three days with annual refreshers where as some staff had not had an update for more than two years. Basic life support was not up to date but the manager said there was a trained nurse each shift as this was a nursing service and they had recently been trained on using a defibulator at the service. Other training was not up to date and we could not see how training delivered was sufficient or if all staff had a sufficient understanding of how to put the training into practice, as there was no competency assessment or recorded appraisals. A number of people had epilepsy and care staff had not received training.

We asked the manager how nurses kept up to date with revalidation which is around evidencing best practice and demonstrating nurses continued competence. The manager told us nurses completed in service training modules and specific training around people's individual needs such as male catheterisation and life- saving skills. However the manager was not providing staff with regular supervision, reflection of practice or annual appraisal of their performance so it was difficult to see how they were assessing the performance of their staff and how they were identifying areas for improvement or development.

Staff received supervision but these were only held once a year and there were no annual appraisals of staffs performance. Staff when spoken with were not clear how often they received supervision but felt supported at work. Monthly team meetings and daily handovers were held at the service.

This was a breach of Regulation 18: Staffing.

Care staff were asked if people had health action plans but they were unaware of these. All health appointments were undertaken by senior staff. The manager told us people did have health care plans but we found information in these varied. We were unable to see when some people had last seen by a dentist or other health care professionals other than the GP and community nurse for one person. One person's records showed the last date of them going to the dentist in 2011, which meant records were either not being updated or staff were not proactive in supporting people with their health care needs. One person

had recently gone into hospital due to health complications, as they were significantly constipated which could have been avoided with closer monitoring.

When people went to hospital staff said where they went with them and took with them their original medicines and medicine records. However there was no other information sent with them which might help staff unfamiliar with people's needs. We discussed this with the manager and said a one page profile might be really helpful particularly as people were said not to like changes to their routine and loss of familiarity.

Records were kept of what people were eating and drinking and when people used the toilet. The nurses knew how much fluid people should be taking and we saw people given the opportunity to drink regularly. We saw from records that fluid intake was high and output was also measured. Staff were also monitoring people's weights and weights were fairly static for those we reviewed. However one person had not been weighed since 2014 and there was no information as to how staff monitored their weight and risk of malnutrition. Their food record showed regular fluid but not about how much they were eating and we saw the person was very slight.

One person was having falls without significant injury did not have a falls risk assessment in place and there had been no contact with the GP or falls prevention team. They had no walking aids and were reliant on staff to support them with their mobility. The falls recorded indicated a change in their mood which we considered might be linked to changes in their seizure activity which had not been considered by the service. Staff told us that since coming to the service their health and skin care had improved. There was some evidence that staff identified changes to people's health and in particular in relation to seizure activity and anticonvulsant medication had been reviewed.

This was a breach with Regulation 12- Safe care and treatment.

The manager told us they had made an application for Deprivation of Liberty safeguard for a person who would be unsafe to leave the service independently and who lacked capacity to make decisions. Another person who had capacity was able to go to the local shops/town but due to concerns about their past behaviour there was a behavioural contract in place which they were required to follow. This was not a progressive plan. For other people staff said they were there voluntarily and had no objection to being there. Staff spoken with were not observed as promoting choice or effective decision making and had limited understanding of the MCA or DoLS. Some training/guidance had been provided to staff but staff were not able to demonstrate sufficient knowledge of the Mental capacity Act. We also felt practices observed did not promote people's choice or independence. Staff held people's cigarettes and people were permitted to smoke each hour which felt unnecessarily restrictive.
This was a breach of Regulation 11: Need for consent.

People were observed at lunch time. There was limited opportunity for people to be involved in meal planning or the cooking of food. Some people had set days in which they were supported to cook a meal for themselves. One person said their day was Wednesday. On the day of our inspection one person was preparing their meal. However staff told us they put together the menus and they ordered and shopped for the food. One person said they had a bus pass and did go shopping one day a week to buy the ingredients for the meal they were going to cook but were not involved at other times.

The lunch time experience for people was poor. The lounge/dining area was used by five out of the six people living in the service. Staff told us the meal was 12.00 pm to 12.30 pm although it was served at 1.00 pm. Two people sat at the table to eat and then another person came in and went to sit at the table, staff told them they had to wait although their food was on the serving trolley getting cold. They became angry

when told this. We asked staff why they were expected to wait and staff said they did not get on with the person already eating their dinner. Another person also eating at the table by themselves was approached by another person who went to sit down and staff asked the person if they minded because again there were issues of compatibility. People ate their food with minimum interaction with staff who did not sit with people whilst eating and just took people's plates away when they had finished without any other interaction. One person ate dinner, pudding and this was followed by snacks which were not conducive with healthy eating.

We observed that there was another room which was not fully utilised and we asked why there could not be a separate dining area for people to help minimise the tensions between people. This had not been considered.

Requires Improvement

Is the service caring?

Our findings

Throughout our observations we found interaction with people was minimal. Staff were always present in communal areas but stood up rather than sitting with people. Staff also spent time talking to each other without being inclusive. People did not go out and there were no plans for them to do so that day. One person was watching their favourite television channel but no one else was. Staff did not engage people in anything throughout the day except for the one person who was observed cooking.

In discussion with staff and through our observations we found the care provided was very task focused and not around the expressed needs and ability of individuals. For example people were not permitted to sit where they chose. We spoke with staff about people's needs and they described their needs in relation to tasks they performed for people "we get their food", "we get them dressed" and so on. When asked about choice such as could a named person choose their own clothes in the morning staff replied, "We have to get their clothes out for them?"
This was further evidence of a breach of Regulation 11.

Throughout personal care we saw one person supported with moving and handling. This was done appropriately and then staff assisted the person with their meal. We noted that staff did not talk to the person or explain what they were doing/what they were eating. This person had limited interaction throughout the day and was quite distressed whilst being assisted to move and staff did not attempt to reassure them.

When speaking to staff about people's needs one staff member described people in terms of their behaviours, which were negative rather than their skills or attributes. For example we were told one person was "Always misbehaving" and when asked what people do throughout the day staff said, "They're not interested anymore."

Another staff member was more positive and talked about encouraging people and stated a person could go back to bed if they wished.

Staff told us they respected people's dignity and privacy by 'knocking on the door before entering their rooms and closing people's doors when they were dressing/undressing. 'However later in the day we observed a person going to the toilet, staff were standing outside and the door to the toilet was open. We also noted staff referring to people as patients although they lived in their own home and were not in a hospital. Staff were also referring to people by their surnames and even using these when addressing them. The manager said one person liked to be addressed this way but it was not clear if everyone did. The language used in people's records was also not particularly person centred. For example it referred to people in terms of their compliance levels. We asked the manager about person centred planning and they told us people were not able to participate in their care planning.

It was not clear how people were able to express themselves where they had no verbal communication. Staff

told us one person could not always communicate their needs but we could not see how staff supported or encouraged this through pictures, symbols, or information technology.

We were unclear how people were consulted about their needs in a meaningful way. People could not tell us what their care plan was. One person told us there was a "Patient Forum" each Monday and said it was when, "staff sit down with us and we have tea and cake." We asked people what was discussed they were unclear only to say whether they liked the food.

Reviews of people's needs were held, which family members were invited and other health care professionals but care staff were not invited and did not have an awareness of how to support people in a positive way and help them develop their interpersonal skills.

Requires Improvement

Is the service responsive?

Our findings

One person told us they were happy with the service. They said, "I can talk to staff and did small tasks including laundry around the home." We saw limited activity for people or the opportunity to participate in things appropriate to their needs. One person was confined to bed and had very little interaction from anyone other than staff and relatives. We were concerned that they were isolated, but the response to the question of how this was managed was, "We turn the TV on for them sometimes or the radio." We could not see how staff were promoting their well-being.

The day before our inspection we rang to ensure people would be in for some of the day and available to talk with us. Staff said people had been out the previous day so would all be in. The previous day some people had been to the zoo and staff told us there was one planned trip a month which at least two people did not participate in. One person who was more independent had set activities on several days but otherwise activity was limited and restricted to time in the service, or out with relatives. Minibus trips were provided twice each week but were just that a ride in a minibus with no other purpose. One person had been to London recently.

Another person was observed sitting throughout the day without interaction from other people using the service and minimal interaction from staff. Their care plan stated they liked television and they were observed watching it. It also said to offer them the opportunity to go out each day. However staff told us they did not like going out and rarely did. This was the case when we looked at their daily notes and saw no mention of activity. Their care plan stated that leisure activities should be introduced by the person being involved and deciding on suitable activities but there was no evidence of this happening. A lot of activity was centred around house hold tasks such as people doing their own laundry and making their own bed.

The care and recording of people's needs did not tell us how staff could enhance people's quality of life. Some people had visits from family members but some people had no contact with family or friends. This was particularly frustrating for one person who did not like the people they were living with. People's care plans did not include what a good day/bad day would look like for people or what their life experiences had been which might help staff provide care which was more individualised.

Some 'behaviours' were managed by staff by a balance of penalties for negative behaviour (arguing, incontinence and swearing) and incentives for positive behaviour ie compliance. The incentive was to take money away for episodes of negative behaviour and to give financial incentives for positive behaviour. We asked staff how this plan had been devised and if there had been discussion with other health care professionals such as psychologists to see if it was the most appropriate way to encourage positive behaviour. It had not.

The plan did not consider why behaviours were occurring or if there was anything other than money which would motivate a person and act as an incentive to encourage positive behaviours. We observed behaviour which was as a direct result of the environment people were living in and how their care was delivered. For

example one person started to swear profusely when told to wait for their dinner although it had been brought through by staff. We observed tensions between the people living at the service and the limited, positive engagement people had with staff and lack of opportunity to participate in the wider community. Staff told us some people required a rigid routine and were unable to adapt. For one person this centred around getting up, meals and going to bed with no structured activity other than television. However this person did go out with family and staff said they could take them to the doctors which they accepted so we felt they were able to cope with changes in their routine but staff did not enable this to happen very often. Goals for this person were around accepting, recognising and participating in personal care. There were no other goals set.

Some of the plans in place had been so for a number of years and were not progressive in terms of developing the plan to enable the person to do more for themselves having earned trust from staff. For example a behavioural contract was put in place in 2010 and had been reviewed but it was not clear with whom. This would suggest that the risks to this person had neither increased nor decreased which is not very realistic.

We observed one person who was ageing and struggling with different aspects of their care, mainly their mobility and increase risk of falls. We observed them being unable to get out of the low, leather chairs available without staff assistance. Another person spent every day in bed; they only had interactions with staff when they were assisting them with their personal care. One staff said they occasionally spent time with them but there appeared to be no plan to reduce their isolation other than alternating the radio with the TV. Another person had a mobile phone but said they were always running out of credit. They had been left on a pay-as-you-go system whereas a contract could have been found for them that was affordable and manageable.

This was a breach in Regulation 9: Person centred care.

We asked about reviews and feedback from people using the service and were told reviews were held through the clinical commissioning group who undertook reviews of the placements.

The manager told us there had been no complaints but it was clear people would need support to raise concerns and the complaints procedure was not accessible. The culture of the home did not promote a positive atmosphere where people had an equal voice. There were no advocates and not all people had someone who could speak up on their behalf. There was no information around the service about how they could raise a concern and who too

This was a breach of Regulation 16: Complaints.

Requires Improvement

Is the service well-led?

Our findings

The service was not well led. Staff said that they had their own meeting once a month with the manager and were able to discuss how the service was going and if they had any concerns which they said they did not.

All staff said they felt that the manager was approachable and they felt supported although we saw limited use of formal supervisions. These were only held once a year. The manager told us they often worked shifts, including nights so worked alongside staff so was aware of their practices but was unable to demonstrate any discussion around their individual work performance outside of the planned supervisions. .

There were clear lines of responsibility with the nurses taking the lead for ordering and administering medication, and escorting people to health appointments or participating in reviews. The manager undertook most of the training himself for which he told us he had the appropriate train the trainer certificates to do so.

There was limited involvement with the wider community other than one person going out by themselves to the local shop and to town. One person had an advocate but no one else did. The manager told us that Mind the mental health organisation who promotes positive mental health and social inclusion had been involved in 2013 when the service was registered as an independent hospital but not since. They also said advocates would only be involved if there was a specific issue. There was one person with poor mental health, no family and unhappy with the people they were living with so we felt there was a role for independent advocates for people to ascertain what people wanted for themselves and their future. This meant the service was not inclusive and part of the community. Most people had limited involvement in the community in which they lived.

There was no information in the home to help people and their visitors know more about the service such as about advocacy or the Local Authority safeguarding team. There was nothing to familiarise people as to the day, what activities were taking place or a photo boards showing people what staff were on duty, which might also be helpful to visitors.

We looked at the Statement of purpose which was out of date and made reference to rehabilitation but no one had moved from this service from many years and we saw little attempt at helping people to move on to alternative accommodation which might be more appropriate to their needs.
This was a breach of Regulation 12: Statement of purpose.

The manager told us he and other share- holders owned the service and that the other shareholders had no direct input into how the service was managed. There was no evidence of service audits either internally or by external agencies in recent years. There were audits around health and safety but none around people's experiences or how they felt about living at the service.

We asked for details of incidents/accidents/notifiable events or recent safeguarding's and told there were none other than a number of recorded incidents. Two people had been hospitalised fairly recently and we had not been notified. We looked at incident records which recorded the incident and action taken but not how they linked to the persons care plan and risk assessment. For example falls had not resulted in a risk assessment being put in place or any exploration as to if falls were occurring due to medical factors.

There was information about maintenance and servicing of equipment and risk assessments in the event of fire and fire plans. We did not look at these in any depth. There was no individual assessment of risk so we were unclear as to how people would react in the event of an actual fire or what support they might require in terms of their evacuation.

This was a breach of Regulation 17 Good Governance.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose
Treatment of disease, disorder or injury	The statement of purpose was not updated or reflective of people's needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment of people was not appropriate or proportionate to identified risks or taking into account people's rights to decide and chose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Staff had insufficient knowledge of the Mental Capacity Act 2015 and did not sufficiently promote people's choices and independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not always being assessed to help identify risks to their health and well- being so these could be managed.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service was not ensuring people were given what they were entitled to without unnecessary restriction which could amount to financial abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective complaints system as people would need support to raise concerns and most did not have access to independent advocacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate systems and processes in place to ensure the service operated effectively and was compliant with regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing It is the provider's responsibility to ensure that the staff that they employ have the skills and competency to carry out their duties.