Faircross Care Home London Limited

# Faircross Care Home London Limited

## 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** |

# Summary of findings

## Overall summary

This inspection took place on 26 April and 2 May 2018 and was announced. The provider was given 48 hours' notice as the service is a small home for adults with learning disabilities who are often out during the day. We needed to be sure someone would be in during out inspection.

This was the service's first inspection since it registered with us in January 2017.

Faircross Care Home London Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Faircross Care Home London is a terraced house in east London. It can accommodate up to five people. At the time of our inspection four people were living in the home. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was 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.

People were not protected from avoidable harm and abuse. The registered manager had not appropriately identified or escalated incidents to the local safeguarding team. Incident records had been compled using inappropriate language and there was no recorded follow up action to ensure incidents were not repeated.

Care plans and risk assessments lacked detail. Significant risks faced by people had not been appropriately identified and measures in place to mitigate risk were insufficient. Assessments of people's needs were not robust and this was reflected in the lack of detail in the care plans. People lived with complex health conditions, but staff had insufficient information about how to respond to ensure people received appropriate care and support.

Staff had not been recruited in a way that ensured they were suitable to work in a care setting. Staff had not received the training and support they needed to perform their roles.

The provider's complaints policy did not inform people of the expected timescale for response to their complaint, and contained inaccurate information about the role of CQC in complaints. Survey's showed relatives had raised concerns but these had not been captured as complaints.

There was no clear vision or strategy for the service. The registered manager and provider did not complete

audits or checks on the quality and safety of the service. There was no plan in place for the improvement of the service.

Information about people's capacity to consent to their care was not always clear. When people had been assessed as lacking capacity to consent to their placements appropriate applications had been made under the Mental Capacity Act (2005) to deprive them of their liberty. People who were not subject to deprivation of liberty safeguards were able to access the community when they wished.

People and staff had developed strong relationships with each other. We observed positive, compassionate interactions between staff and people who lived in the home.

People were supported to eat and drink in line with their preferences.

People were supported to maintain relationships that were important to them.

We identified breaches of seven regulations relating to person centred care, safe care and treatment, safeguarding adults, complaints, good governance, staffing and fit and proper persons employed. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

## The 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. Systems did not operate effectively to protect people from avoidable harm and abuse.

Risks faced by people had not been appropriately identified or mitigated against.

Staff had not been recruited in a way that ensured they were suitable to work in a care setting.

The service took action to improve the systems for managing people's medicines during the inspection.

The home was clean and free from malodour.

### Is the service effective?

**Inadequate**

The service was not effective. Assessments of people's needs were not robust and care was not designed in a way that ensured people's needs and preferences were met.

Information about people's health conditions was unclear and not shared across the staff team appropriately.

Staff had not received the training and support they needed to perform their roles.

People had consented to their care where they had capacity to do so, but it was not clear staff understood how the Mental Capacity Act (2005) applied to people living in the home.

People were supported to eat and drink in line with their preferences.

Adaptations had been made to the home to ensure people's needs were met.

### Is the service caring?

**Requires Improvement**

The service was not always caring. Not all important relationships were captured in people's care plans.

People were supported in a kind and compassionate way by staff.

We saw staff responded to people appropriately and respected their individuality.

People were treated with dignity and their privacy was respected.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive. Care plans were reviewed regularly but were not always up to date. Care plans were not in an accessible format.

The provider's complaints policy was not sufficient and the service had not maintained appropriate records of concerns raised.

The information about people's end of life wishes was limited to who they would like to arrange their funeral.

People were supported to attend a range of activities.

## Is the service well-led?

**Inadequate**

The service was not well led. There were no effective systems in place to monitor or improve the quality and safety of the service.

There was no clear vision or plan for developing the service.

Feedback had not been used to drive improvements.

# Faircross Care Home London Limited

**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.

This inspection was the first inspection of the care home since it registered with us in January 2017. The inspection took place on 26 April and 2 May 2018 and was announced. We gave the service 48 hours' notice of the inspection as it is a small service for adults with learning disabilities who are often out during the day. We needed to be sure people would be in during our inspection.

Before the inspection we asked for feedback from the local authorities who commission services from the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people who lived in the home and four staff members including the registered manager, the nominated individual, and two support workers. We reviewed three care files including needs assessments, care plans, risk assessments, medicines records and records of care delivered. We reviewed four staff files including recruitment, training and supervision records. We also reviewed various meeting records, surveys and other information relevant to the management of the service.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe living in the home and told us they would tell staff if anything happened where they did not feel safe. Staff told us they would report any concerns to the manager. We saw a member of staff had been suspended from work due to a person who lived in the home making an allegation of abuse against them. The registered manager told us they had not raised a safeguarding alert about this as they had investigated the allegation themselves and decided it was unfounded. The registered manager had not identified this as abuse and had not raised an alert with the local safeguarding authority.

Incident forms showed there had been incidents of violence and aggression between service users and these had not been identified as possible abusive situations. The incident forms were poorly completed and used inappropriate language when referring to people's behaviour. For example, there were repeated references to people "kicking off" rather than descriptions of the behaviours. It was not clear what action was taken to prevent incidents recurring. The safeguarding policy did not include information about how to raise an alert and did not include contact details for the local safeguarding team. This meant there was a risk that people were not appropriately safeguarded from abuse and improper treatment.

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

People's care plans contained information about the risks they faced in living their lives. However, the measures in place to mitigate these risks were not always clear, and some risks had not been identified or mitigated against. For example, one person had a history of behaving in a way that put themselves and others at risk of harm. There was no risk assessment in place to address this behaviour and no guidance for staff to ensure they could respond appropriately.

On the second day of the inspection the registered manager showed us a risk assessment they had re-written following our concerns about unmitigated risks. This remained insufficient and one risk that had been specifically raised by the inspector as not having been addressed remained unassessed. In addition, the risk assessment referred to positive behaviour support guidance that did not exist. The registered manager confirmed to us that there were no positive behaviour support plans in place within the service.

Staff knew the people who lived in the home well, and where they were familiar with people and their behaviours they were able to describe the measures they put in place to mitigate risks. However, as these were not clearly captured in the records there was a risk that should regular staff be unavailable, new or agency staff would not have the information they needed to mitigate risks.

The staff completed audits of medicines held by the service. However, we found these were not correct. For example, there were 100 extra paracetamol tablets in the home than recorded in the audit. The registered manager told us this was because they had not returned the extra tablets to the pharmacy yet. A new person had recently moved into the home, and the records of the medicines they had brought with them, and had delivered since were not clear. It was not possible to work out how much medicine should be in the home.

This meant there was a risk of poor stock control and medicines going missing. This meant the systems of medicines management were not operating safely.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they thought there were enough staff on duty and enough staff employed that absences were easily covered. The rota was structured with two care workers during the day with the registered manager or provider giving additional support if required. People told us they did not have to wait to be supported and there were enough staff to support them to go out and do activities when they wanted.

Records did not demonstrate safe recruitment practice had been followed. In one file the application form was dated six weeks after the interview had been completed and despite previous employment in the care sector, references were not from these employers. There was an undated reference from an employer who was not listed in the staff member's employment history. Another staff member's file did not contain any record of the interview process and their application did not include dates of their employment history. There was no record this has been explored with the provider.

Providers are required to ensure staff are suitable to work in a care setting by checking they are not barred from working in care and exploring their criminal records. In England these checks are completed by the Disclosure and Barring service (DBS). One staff member's file contained a DBS check from their previous employer and there was no record they had signed up to the DBS update service. Another staff file contained a disclosure Scotland form, but there was nothing within the staff members file to suggest they had recently lived or worked in Scotland. In addition, there was no risk assessment or recorded conversations regarding disclosures found on DBS checks for staff working in the service. This meant the provider had failed to ensure staff were suitable to work in a care setting.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff supported them to take their medicines. We saw medicines were stored securely in an appropriate cabinet in the office. The home used printed medicines administration records to record medicines administration and we saw these had been completed to show people had taken their medicines as prescribed. We noted that when medicines were administered on an 'as needed' basis the reason for administration was not recorded. This meant it appeared there were gaps in the administration records.

On the first day of the inspection there was insufficient information about the support people needed to take their medicines, or information about people's medicines such as side effects and purpose of the medicine. People had been prescribed medicines on an 'as needed' (PRN) basis but there was no guidance to inform staff when to offer or administer these medicines.

On the second day of the inspection the registered manager had written appropriate medicines support plans and PRN guidelines to ensure staff had sufficient information to administer medicines in a safe way.

People received support to manage their personal finances. There were clear systems in place to protect people from the risk of financial abuse by staff. The staff checked the balances daily and two staff signed for each transaction. We checked the balances and found they matched the records. However, where people were more independent in managing their finances the systems in place to ensure the risks were mitigated were not clear. On the first day of the inspection one person's care file stated they were independent in

managing their money and held both their bank card and cash. However, another part of their care plan had identified they were prone to overspending and did not have full capacity to manage their finances. On the second day of the inspection their updated file said that their relative managed their finances for them. This meant it was not clear how the risks associated with their money had been mitigated before the second day of the inspection.

One person who lived in the home showed us around and we saw the home clean and free from malodour. Staff told us personal protective equipment was available for them to ensure people were protected by the prevention and control of infection. The daily cleaning tasks were included in the daily handover sheet and staff signed to indicate when cleaning tasks had been completed.

Inadequate

# Is the service effective?

## Our findings

The registered manager and provider told us they received referrals from local social services teams. They said that following the receipt of this information they completed an assessment to decide whether they were able to meet people's needs. However, this was not supported by the records in the service. The needs assessment completed for one person who had recently moved into the service was not robust and had not been fully completed.

For example, the sections regarding sexuality, whether known risks were current and the background history of illness or social history were all blank. Other sections contained only brief notes and did not demonstrate an exploration of the person's needs and the home's ability to meet them. For example, regarding daily living skills the assessment stated, "Can do everything on his own." Information provided by social workers and the previous placement identified specific risks that could put the person and others at risk of harm and violence. These had not been explored in the assessment of their needs.

People living in the home were diagnosed with a range of physical and mental health conditions. People had hospital passports and health action plans within their care files. These are documents considered best practice when supporting adults with learning disabilities to access healthcare services as they ensure all information about people's health is held in one place. However, the information about people's physical and mental health needs lacked detail. For example, one person's care file referred to them having a condition whereby they described mental health symptoms as physical pain (somatisation). There was no information about this within their health file. Another person was prescribed a medication that can be used as either an anti-convulsant for epilepsy, or a mood stabiliser for people with mental health conditions. The registered manager told us this was prescribed for epilepsy but there was no information about how to support this person in the event they had a seizure and no records of any neurology appointments or referrals within his file.

Although staff recorded the appointments they attended with people it was not clear this information was shared appropriately across the staff team. One person's care file showed they had recently received a life changing diagnosis. We asked staff if they were aware of the outcome of recent hospital admissions and they told us they were not. One staff member said, "We're still waiting for feedback from the hospital. I know the discharge letter is in the file but I've not looked at it as I'm not their keyworker. We wait to be told. If it was the person I keyworked I'd be all over it." Keyworking is a system where each person who lives in a service has an allocated staff member to lead on providing their support and updating their records. This meant staff did not have important information about this person's current health needs that were affecting their day to day life.

Records showed people had attended a local day centre regularly for a considerable length of time. However, there was no recorded correspondence or communication with the other services involved in providing support to people who lived in the home. This meant there was a risk that important information about how people were supported was not shared appropriately.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we registered the provider we expressed our concern that they had not included any budget for training of staff. The provider told us they had added this, and were now providing their staff with training. However, records showed the service relied on training staff had received from previous roles, and did not provide them with the training they needed to meet people's needs. Everyone living in the home had a diagnosed long term mental health condition, and several could present with violent and aggressive behaviours but staff had not received training in these areas. Some staff files contained certificates relating to online learning courses but it was not clear these had been assessed. One staff member's file contained records which showed their training in fire safety had expired in December 2016. None of the other staff files reviewed contained any records of fire safety training.

Staff told us and records confirmed they received regular supervisions from the registered manager. The staff we spoke with told us they found supervisions supportive and helpful. They told us they included discussions about their role and development. However, records showed that key issues were not discussed in supervision meetings, and not all staff were receiving supervision. For example, one staff member had been suspended from work but there was no record of any discussion or feedback to them upon their return. Another member of staff had no supervisions recorded since November 2016.

The above issues with training and supervision are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. One person who lived in the home had been assessed as lacking capacity to consent to his care and treatment. Records showed the provider had submitted an appropriate application to the local authority to deprive him of his liberty. The local authority had not yet authorised the deprivation of liberty.

We saw that the other people who lived in the home were free to come and go as they pleased. Staff reminded people to take reasonable safety measures as they left the house. For example, one person was reminded not to behave in a certain way while in the community. However, records regarding restrictions on people were not consistent or clear within the care files. For example, one person's care plan stated that until they were familiar with the local area they would be supported to access the community by staff at all times. In discussion with the provider and the registered manager it became clear this person was not always supported by staff when accessing the community. Likewise it was not clear whether the service had completed capacity assessments, or made appropriate referrals for these to be completed, in relating to managing people's finances.

Staff spoke to us about the importance of offering people choices and respecting their decisions. Staff knew who was able to go out without support and understood they were not allowed to stop them doing so if they wished. However, no staff had received training in the MCA and this was reflected in their answers to questions about the MCA. While staff understood that capacity could fluctuate, and that people had the right to make their own decisions, it was clear they had not received training in relation to what steps to take if someone lacked capacity to make specific decisions about their care and treatment.

We saw people were supported to eat foods of their choice throughout the inspection. One person had recently experienced a change in their appetite due to their health conditions and staff demonstrated sensitive persistence in encouraging them to eat and drink. We saw staff asked exactly how this person wished for their food to be prepared and followed their precise instructions. People were involved in planning the menu for the home, and this was captured in house meeting records. People told us they liked the food, and that it was varied. One person said, "The food is not boring. [Support worker] is a good cook." Although people's dietary preferences were not captured in their care plans, staff were knowledgeable about them and were able to list what foods people liked and how they liked their foods to be prepared.

People showed us around the home and told us they had been involved in choosing how their bedrooms had been furnished. One person's mobility needs had changed and we saw additional handrails had been installed to support their mobility. This meant people's individual needs were met by the design of the service.

Requires Improvement

# Is the service caring?

## Our findings

Throughout the inspection we saw staff interacted with people in a kind and compassionate manner. Staff spoke gently and asked people questions and respected their answers throughout. For example, we saw one person repeatedly made the same gesture. Staff were able to explain this meant the person wanted to go out for a drive. However, on the day of the inspection there were no drivers available. Staff explained this in a clear way the person could understand and supported them to go for a walk to the park instead.

On the second day of the inspection we saw this person was getting ready to go out with their family and from their smiles and energetic behaviour it was clear they were looking forward to this. However, their behaviours were causing other people who lived in the home to become anxious. We saw staff noticed this and supported the person to engage in an activity in a different room so as to not distress their fellow housemates. This clearly demonstrated staff recognised and responded appropriately to people's emotional needs.

Although care plans did not contain information about people's sexuality and sexual needs staff responded to questions about these areas in a way that demonstrated a compassionate and sensitive approach. For example, one staff member described how one person needed support to ensure they didn't express their sexual needs in public spaces. The staff member explained how the person was encouraged to move to private areas, but the needs being expressed were respected.

With regards to sexuality, support workers were confident that no one living in the home identified as gay, bisexual or transgender. In conversation it was clear this was based on knowing the people and having had conversations with them about relationships. Staff told us it would not affect how they supported people if they did identify as gay, bisexual or transgender. One support worker said, "I respect people, it's their needs and it doesn't affect the care I give." A second support worker told us, "I don't think it would affect how I support people." They went onto explain how they had previously provided support to a gay man.

One person was supported with their relationship with their partner. During the inspection the person was supported to buy a new mobile phone and we saw staff supported them to ensure their partner's phone number was still in their address book. The person told us they were able to arrange to see their partner themselves. The home's facilitation and support of this relationship was clearly shown by the photographs of this person and their partner on display around the home. Despite the long term nature, and clear importance to the person of this relationship, their partner was not mentioned in the section of their care plan regarding relationships. In all of the care plans reviewed the relationships care plan referred only to family relationships and did not include friendships, or other significant relationships that may be important to people. This was discussed with the registered manager and provider who told us they would ensure information about relationships with people who were not immediate family members were included in care plans.

People told us, and observations also demonstrated people were given privacy when they wished. People were able to spend time on their own in the bedrooms. We saw staff knocked and respected the privacy of

people's bedrooms. People were encouraged to take pride in their appearance, and individual preferences for dressing style were included in care plans.

Requires Improvement

# Is the service responsive?

## Our findings

The provider had a complaints policy. However, this did not include information about the expected timescales for response and contained inaccurate information about the role of CQC in responding to and investigating complaints. The provider told us they had not received any complaints and there were no records of any complaints within the service. However, in the relative's surveys three relatives stated they had raised concerns. Although all three relatives stated they were happy these had been dealt with there was no record of the nature of the concern within the service. This meant it was not clear complaints had been used to improve the quality of the service as they were not captured.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were divided into different areas of support, including personal care, health, daily living skills, activities, use of transport and night time support. The descriptions of the support to be provided by staff to support people to meet their needs was limited and did not describe how staff should support people. For example, one person's care plan stated, "Staff will need to support him to limit his intake of energy drinks." There was no guidance about how to provide this support. In the section regarding communication the care plan stated, "staff need to understand him when he is agitated." This is not a clear description of how to provide support to an agitated person.

On the second day of the inspection the provider showed us they had updated care plans in response to our feedback. However, the plan remained vague and included references to other services that could not be explained. For example, the care plan referred to "CGL" repeatedly but when the registered manager was asked what this stood for she was not able to tell us. The care plan stated repeatedly that staff should "encourage," "support," and "prompt" various aspects of care but did not describe how to do any of these things. Another person's care plan stated that staff needed to ensure the person had "cleaned himself well and to a good standard." However, there was no information about how to make that judgement or provide that support.

People told us they had keyworkers who they met with regularly. We saw records of keyworker meetings. These showed people talked about the activities they had completed and what activities they wanted to try next. However, despite being reviewed monthly and signed off by the registered manager, care plans were not kept up to date. For example, a day centre attended by people living in the home had closed but care plans still referred to people going there each week.

It was not clear that care plans were being consistently followed. For example, one care plan referred to a rewards system being in place to reduce a behaviour which put the person at risk of harm. There was no record within the care notes to show this was being followed. Another person's care plan stated they required encouragement to try new activities but the records did not show any new activities had been tried. Despite living in the home for two months there had been no meetings to consider this person's care plan and to check that it was an accurate reflection of the support they wanted and needed to live their life.

Records showed people attended a range of activities, both independently and with the support of staff where they needed this. People were supported to go out for drives, walks, regular meals out. During the inspection one person changed their mind about attending their planned activity and decided to attend the local library instead. They told us this was one of their favourite things to do. Their care records showed they regularly went to the library.

People had been supported to complete a feedback survey about their experiences of living in the home. Two people had recorded that they did not feel involved in planning and reviewing their care plans. There was no action plan associated with these surveys and it was not clear what actions, if any, were planned to ensure that people felt involved in reviewing and updating their care plans to ensure they reflected their preferences. Care plans were typed and stored in folders kept securely in the office. Although some of the people living in the home were able to read well and engage with large written documents, this was not the case for everyone who lived there. Care plans had not been made in an accessible format. This may have affected why people did not feel they were involved in the review and update processes.

People's care files contained a section to record their end of life care wishes. However, these were limited to stating who they wished to be involved in arranging and planning their funerals. There was no consideration of preferred place of death or what types of treatment people did, and did not, want to consider when they approached the last stages of their life. The provider submitted a policy regarding palliative care and end of life care. This described ensuring people were supported to die with dignity in the place of their choosing. However, it also stated that all staff would be trained in end of life care but this had not happened. This meant there was a risk that people would not receive the support they needed if they reached the end of their lives.

Inadequate

# Is the service well-led?

## Our findings

Records showed staff completed weekly checks on the safety of the service. They recorded that they checked the water temperatures. However, they did not actually write down the temperature of the water. This meant it was not possible to tell if the water was at a safe temperature. This had not been identified as an issue by the registered manager or the provider. Likewise, issues with medicines audits, where the counts did not match the medicines in stock had not been identified by the management team within the home.

We asked the registered manager and provider to show us any checks or audits they completed on the quality and safety of the service. The provider told us, "We don't do any checks like that." Although the registered manager signed to indicate care plans were up to date, the checks they performed were ineffective as they had not identified the discrepancies and out of date nature of care plans found during this inspection.

People who lived in the home and their relatives had been asked to complete feedback surveys. These were stored in the home but there was no record of any analysis or action plans in relation to the information contained within the surveys. This was despite the surveys completed by people raising issues with the quality of the support they received.

Incident forms contained a section to be completed by the registered manager in relation to follow up actions. This had not been completed. Nor were incidents audited and reviewed on a regular basis. This meant there was no analysis of themes to incidents and there was no plan in place to ensure lessons were learnt and mistakes not repeated. The registered manager demonstrated a limited understanding of safeguarding adults processes and had not escalated concerns appropriately.

Following the inspection the provider contacted us with an initial action plan, and with subsequent updates. Although the action plan showed the provider had understood the extent of our concerns, the action plan did not clearly state who would complete the actions. The provider told us the registered manager had left the service, and a replacement was in the process of joining the service. It was not clear who was leading the improvements required in the interim.

Organisations are required to have a statement of purpose. A statement of purpose is a document which outlines the aims of a service and how they intend to achieve those aims. The provider submitted a statement of purpose document. However, this contained a list of things a statement of purpose should contain, not an actual statement of purpose. This meant the aims, objectives, vision and values of the organisation were not clear and easily available to people and staff.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not protected from avoidable harm and abuse as incidents were not appropriately identified or escalated as safeguarding concerns. Regulation 13(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The service was not responded or acting on complaints appropriately. Regulation 16(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment processes had not operated to ensure staff were suitable to work in a care setting. Regulation 19(1). |

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<br><br>People's needs had not been appropriate assessed, and care plans lacked detail and were out of date. Regulation 9(1)(b)(3)(a)(b) |

**The enforcement action we took:**

We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people had not been appropriately assessed or mitigated. Medicines management did not ensure people's medicines were managed in a safe way. Regulation 12(1)(2)(a)(b)(g) |

**The enforcement action we took:**

We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes had not operated effectively to monitor and improve the quality of the service. Regulation 17(1)(2)(a)(b) |

**The enforcement action we took:**

We required the provider to submit regular updates regarding progress made to address our concerns.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received the training and support they needed to perform their roles. Regulation 18(2)(a) |

**The enforcement action we took:**

We issued a warning notice