Selborne Care Limited

Selborne House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

We inspected Selborne House on 28 November and 01December 2016 and our inspection was unannounced. At our last inspection in April 2015 we found that the provider was meeting all the regulations we assessed. The local authority had shared some concerns with us about the service and the safeguarding of people so we brought forward our inspection of this service.

Selborne Houses provides accommodation and personal care for 15 adults who have a learning disability. There were 13 people living at the service when we inspected. The home is split into two separate areas called Ascot unit and Beverley unit.

There was a registered manager in place at the time of our inspection. 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 systems in place to audit the quality of the service were not effective because they failed to identify where improvements were needed. The service was not always led in a way that promoted the wellbeing and safety of the people who lived at Selborne House, recruitment practice did not ensure that only staff that were suitable were recruited, medicine management did not ensure people were protected from risks associated with medicine management and care was not always provided in a way that was person centred. Improvements were needed to ensure the home complied with the regulations. You can see what action we told the provider to take at the end of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Medicines were not always managed effectively to reduce the risks associated with them. The provider's recruitment procedures were not always implemented effectively to ensure that staff were recruited safely. Risk to people were not always well managed and the environment was not always maintained in a way that ensured people's safety.

People told us that they felt safe and staff we spoke with were confident that they could identify signs of abuse and would know where to report any concerns. Staff had received some training however further training was needed. Staff lacked an understanding of what Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) meant in practice for the people they supported, which showed that systems were not in place to show that staff training was effective.

People were not always involved in decisions about their care and opportunities to promote people's independence and life skills were not always acted upon by staff. People were not always supported to pursue hobbies and activities that were of interest to them. People were supported to access healthcare professionals and had access to food and drink.

Visitors were welcomed to the service and the provider had a system in place for responding to people's concerns and complaints. However, systems were not in place to ensure that the views of the people that lived at the service were sought and acted upon to influence how care was provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

The risks associated with medicines were not always managed to Protect people from harm.

Risks to people's health and safety were not always identified and managed.

People were safeguarded from the risk of harm because staff was able to recognise abuse and knew the appropriate action to take.

People were not always protected by safe recruitment practice.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always consulted with and staff did not ensure that care was always provided in a way that promoted their human rights.

People were supported by staff that had received some training however, this training was not always implemented effectively.

People were supported to access health care services so that their health and wellbeing was maintained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated in a way that respected their dignity and showed respect.

People did not live in an environment that was well cared for and promoted their independence.

People were not always consulted with about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to do things that they liked and the environment people lived in lacked stimulation.

People knew how to raise concerns if they were unhappy about the service however people's views were not always asked for and acted on.

Is the service well-led?

Requires Improvement

The service was not well led

The providers system to assess and monitor the quality of the service provided was not always effective at identifying any shortfalls.

People lived in a service that was not run in their best interest.

Selborne House

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 visit took place on the 28 November and 01 December 2016 and was unannounced on the first day. It was carried out by one inspector, an expert by experience and a specialist adviser. The expert by experience had personal experience of using or caring for someone who used a health and social care service. The specialist adviser had professional expertise as a nurse.

In planning our inspection, we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/ incidents and safeguarding alerts which they are required to send us by law. We contacted the local authorities that purchase the care on behalf of people, to see what information they held about the service and we used this information to inform our inspection.

We used a range of different methods to help us understand people's experiences. We met and spoke with all the people at the service making observations about their care and treatment. We had conversations with six people who lived at the home and one relative. We spoke with six care staff the administrator, registered manager and the director for professional services. We also spoke with four healthcare professionals.

We looked at four care records to see how care and treatment was planned and delivered. We also looked at records maintained by the home about staffing, training, accidents and incidents and the quality monitoring system.

Inadequate

Is the service safe?

Our findings

We found evidence to show that people were not always receiving the care and treatment they required in order to keep them safe.

Medicines were not always managed to ensure that people were kept safe from the risks associated with them. We saw that a medicine given to manage behaviour on an 'as when needed' basis was administered by two different staff members within close proximity and was not in accordance with the person's protocol. When we asked staff and the registered manager about this there was no explanation of why the medicine had been administered twice. The balance of medicines that we checked with the records indicated that an additional tablet had been given on another day but not recorded. We saw that a person with limited capacity to make decisions about their care or treatment had a protocol in place for medicine to be given to them without them knowing. However, records showed that the correct procedures had not been followed to ensure that this practice was in their best interests. We saw that a balance of medicines had not always been maintained to ensure medicines have been given as prescribed. Medication administration records (MAR) for two people had not been signed when medicines had been administered. Not all medicine profiles were kept up to date when changes had been made by the GP. Some MAR charts had been handwritten but not signed or checked to ensure that information was transcribed accurately. The systems and processes in place did not ensure that medicines would always be administered accurately and safely. Staff told us that they had completed training to ensure they had the skills and knowledge to administer medicines safely. However, there were no records to confirm how their competency was assessed to ensure safe medicine management was carried out in practice. The provider told us following our inspection they reviewed their records and identified three recording errors and that these had not had an impact on people's safety.

We saw that the premises had not always been well maintained and action had not been taken to reduce the risk of injury caused by the environment. We saw that radiator covers in communal areas had been damaged and not repaired. We looked at six people's bedrooms. In one person's bedroom we saw that items of furniture required repair. We saw the back cover of their wardrobe had come loose and had panel pins protruding from it. We saw that there were hanging looped blind cords. We asked the registered manager about what steps they had taken to reduce the risk of harm from the loop blind cords. They told us that the person whose bedroom the blinds were in was supervised at all times which reduced the risk of harm. This did not show a proactive response to the potential risk of harm and was not in line with the department of health guidance on the safe practice of window blinds in care homes (Department of Health Safety Alert 2014). In a second person's bathroom we saw that repairs needed to the shower in their ensuite had not been made in a timely manner. They showed us how they put their finger over the end of the hose to control the water so they could wash themselves, because the shower hose had no head on it. The person told us that the shower had been in this condition for several weeks. In a third person's bedroom we saw that windows that had been damaged had been boarded up. Maintenance records we looked at had not identified these issues of concern and arrangements were not in place to address these concerns in a timely manner. The registered manager told us that there was a high level of wear and tear on the environment because of the needs of some of the people that lived on Ascot Unit. They told us that the Perspex for the damaged window we saw needed to be specifically ordered and that they had taken action to do this. When

we returned for the second day of our inspection some action had been taken to reduce risks and carry out some repairs. This did not ensure that systems and processes were effective and that the premises used by the service provider were always safe for their intended purpose and maintained in a way that ensured people's safety. The provider told us that there had been no incident of harm to people as a direct result of the condition of the environment and that the damage had been caused wilfully by some people who lived at the service.

We saw that one person was mainly supported in their bedroom by a staff member. We saw that they walked around and around their bedroom for long periods of time or they were led around the home by a staff member with only limited engagement from staff. Staff that we spoke with told us that the person spent most of the time in their bedroom and this practice was in place to keep the person safe. The registered manager told us that the person was at risk of falls and they were at risk of being injured by being knocked over by other people living at the service when they were in the communal areas of the home. This did not ensure that the arrangements in place to respond to people's changing needs had been appropriately managed.

We found that the evidence above supports that the provider was in breach of regulation 12. Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Relating to safe care and treatment.

We found the provider's recruitment systems and processes were not always implemented effectively. Staff told us that prior to commencing in post all the necessary pre-employment checks had been completed, including checks with the Disclosure and Barring Service DBS (which provides information about staffs criminal records). We looked at the files of the three most recently employed members of staff. We saw that there were gaps in some staff members' employment histories without an explanation and some inconsistencies between the information staff had provided on their application form and the information received from their referees. Where there was inconsistencies there was no evidence that these had been explored and explanations recorded. For example, records showed that a staff member had worked in a previous care setting but this had not been declared on their application form and therefore a reference from this employer and the staff member's reason for leaving this employment had not been sought. We also saw that there was contradictions on the dates of employment on their application form that had not been explored and clarified. For a second staff member we saw that references had not been sought from their most recent employment and a reference and the reason for leaving their previous employment in a care setting had not been sought. In addition the dates of employment did not give specific dates of employment only the year of employment and steps had not been taken to clarify this information. We saw that for a third staff member they had commenced employment on the day of the inspection and we were told they were on induction and had a DBS in place. Records showed that their application form was incomplete. When we asked the registered manager about their recruitment practice they told us that the staff member responsible for carrying out recruitment had been absent from work. They told us that a new administrator was now in post and was taking action to address the shortfalls. The arrangements in place had not ensured that systems were followed to ensure that staff recruited were suitable.

We found that the evidence above supports that the provider was in breach of regulation 19. Regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Relating to fit and proper persons employed.

Before our inspection there had been a number of safeguarding incidents at the service. The registered manager had appropriately reported safeguarding incidents to the local authority. We had also had concerns shared directly with us prior to our inspection and we had passed this information onto the local

authority through safeguarding procedures. The provider had met with the local authority to discuss the management of safeguarding at the service. One of the outcomes of the meeting was that the provider had requested information from the local authority to assist them with their process of track and learning from incidents. At this inspection we spoke with the registered manager about the management of safeguarding incidents. They told us that there was a system for recording incidents. However, they told us that they had not yet developed a system that could show that learning from incidents had taken place and how they prevented reoccurrence and minimised further risks to people. The provider had conducted some internal investigations following safeguarding concerns being raised. The minutes of these were shared with the inspector and had concluded that allegations against the service had not been upheld by the provider.

The maintenance team performed checks on equipment and we looked a sample of these. We asked to see the fire risk assessment and the significant findings of this assessment. Records showed that this had not been reviewed since 2013 and had not been updated following any changes at the service. We saw that the individual plans to provide guidance to staff about how people should be supported in the event of a fire failed to give any detail specific to the person. For example, it did not include people's mobility needs or any sensory disability and how the risks associated with these needs would be met.

Some people using the service had limited verbal communication skills and were unable to tell us if they were concerned about their safety and if they were protected from abuse and harm. Staff told us that they had received training that enabled them to identify the possibility of abuse and how to take the appropriate actions to keep people safe. Staff told us that they knew who to report to if they had any concerns that people were at risk of abuse. Staff that we spoke with told us that they had no concerns about people's wellbeing or safety.

People who could tell us told us that they felt safe living at the service. In [Ascot House] people told us, "I do find it safe living here. When I have to, I can defend myself, but it gets worrying when service users kick off". And another person told us, "I am safe in a way. I've got challenging behaviours and staff here put safety first". In Beverley House, one person told us, "Yes I am safe living here".

The registered manager told us that there had been a high turnover of staff and they were in the process of establishing a stable work force. They told us that some staff had left because they had not been suitable for the role. They told us that staffing levels were determined by the needs and dependency levels of the people. The registered manager told us that they used some agency staff to maintain safe staffing levels and that they were actively recruiting to vacant posts.

People were kept safe in emergencies. Staff spoken with told us that knew what to do in the event of an emergency. A staff member told us that they had witnessed a person choking and they took action to dislodge the food. They told us they would call the emergency services if they needed to.

Requires Improvement

Is the service effective?

Our findings

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. Some people we spoke with told us that staff gave them choices and asked them what help they needed. However, we saw that staff did not always ask people for their consent in aspects of their day to day care and support.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application for this in care homes and hospitals are called Deprivation of Liberty Safeguards DoLS. When people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. This may include restricting a person's liberty to keep them safe. Under these circumstances the provider is required to submit an application to the supervisory body for the authority to deprive a person of their liberty. The registered manager told us that a number of applications had been made and some applications had been approved. However, although staff told us that they had received training staff we spoke with were not always sure about who an application had been made for, why the decision had been made and if the application had been authorised what they were doing to work within the constraints that had been approved.

Staff told us that they had occasional supervision sessions to discuss their performance and development and that these sessions were helpful. They told us that they could speak with the deputy manager or registered manager when they needed to. The registered manager told us that he had identified that staff supervision sessions needed to take place more frequently and that the quality and structure of supervisions were being looked at. He explained that there had been significant staff changes and that the systems in place to support staff in their role needed to be improved. The registered manager told us that staff who were new to working in care had the opportunity to work through the Care Certificate as part of their induction. The Care Certificate sets fundamental standards for the induction of adult social care workers. We asked to see the records of induction for staff who had recently been employed at the service these records could not be located at the time of our visit.

Staff we spoke with told us that they had completed training relevant to their role. Some staff that we spoke with had a good understanding of people's needs. However, observations we made indicated that not all staff had the knowledge and skills they needed for their role. For example, we saw a number of poor interactions from staff or no interactions from staff. This showed that not all staff had implemented their learning and training into practice and also that staff training and staff performance had not being monitored effectively. Staff training records had not been updated with details of training that staff had completed recently. However, following our inspection the provider shared with us updated information and their training plans detailing where initial training or refresher training was identified as needed.

We saw for people that had difficulties in swallowing food, soft and pureed meals were available. However, we saw that staff pureed all the food items together. This did not ensure that the mealtime experience was a meaningful opportunity for the person to express their choice and experience different tastes and flavours. Staff that we spoke with told us that they had been told to prepare the food in this way. We saw in Beverley unit that people were offered choices of soup or a sandwich at lunch time and some people were supported to prepare their own lunch. One person told us, "I do some cooking the staff help me". Another person told us, "I just made a crumpet myself in the kitchen. I eat out mostly or make a sandwich". People were prompted to put their dishes in the sink and some people washed and dried their dishes. We saw that the lunch time was flexible with people eating at different times. One person chose to eat some of their lunch then they left the kitchen and returned later to eat some more of their food and we saw that staff supported the person to do this.

People we spoke with told us that they had access to healthcare when they needed it. One person told us, "I can see the doctor when I am not very well". Another person told us, "I only need to ask if I need to see the doctor. It is close by, just up the road. They [staff] sort out the dentist for me". We saw that people with diabetes had a care plan in place and this described how their diabetes presented and what staff should do. Staff that we spoke with told us that they knew how to support people with diabetes. However, we saw that the care plans did not include how other health issues would be managed linked to their diabetes for example, skin, feet and eye care. We saw that a person had been admitted to hospital due to their diabetes and their care plan was not reviewed following discharge from hospital to ensure that it was still appropriate. We saw that referrals had been made to other professionals where staff had concerns about a person's wellbeing. For example to the speech and language service.

We saw that the provider had identified that people's care records in relation to their health care needs required improving. A student nurse on placement was in the process of developing Hospital Passports for people, these would ensure that if a person needed to stay in hospital information would be available to healthcare professionals about the person's individual care and health needs and how these should be met. Health Action Plans (HAP) were also being developed for people. HAP are produced in accessible formats to inform people about what they can do to stay healthy and help they can get.

Requires Improvement

Is the service caring?

Our findings

From our observations and people we spoke with we saw that the caring aspect of the support people received varied across the two houses. For example, we saw on Beverley unit that staff were mainly task focused. People had little interaction from staff and we saw that interactions with people were in relation to a task that needed doing and there were few meaningful exchanges between staff and people. For example, telling people it's time for lunch, asking out loud if a person had been to the toilet before they went out. We did see in Ascot unit that people had a more positive experience and staff spent time talking and engaging with people.

We saw in Beverley unit that staff did not always communicate effectively with people and did not proactively support people to express their views and make decisions about their care. Some people had limited verbal communication. However, we saw that no objects of reference or photographs were used to assist with communication and to help people express their views, staff spoken with confirmed these aids were not available. There was no information provided to people in a format that they could understand. For example, we asked to see the menu so we could see what people were being offered to eat and how people were supported to make choices with their food. Staff told us that they could not find the menu to show us and they advised that there were no pictorial menus available. Staff told us that for the people who could not verbalise a choice they knew people's likes and dislikes and that people would let them know if they didn't like something for example, they would push the food away.

In Ascot unit we saw that people had developed relationships with staff members and people spoke mainly positively about the staff who supported them. One person told us, "It is brilliant here but they [staff] are over-protective. I love it, they [staff] do it in my best interests". Another person told that their key worker discussed their care plan with them and that their key worker 'cares' about them. A third person told us that they thought the home was more like a hospital and it was very 'bare'. However, they told us that they liked the staff and they thought the staff were caring. Staff that we spoke with said that there had been a lot of staff changes and the key worker system needed to be re-established. The provider told us that prior to some people moving to the service a meeting took place and agreements were made that the persons environment would look like a hospital ward in order that psychological security would be provided in order to prevent relapse.

We saw that there were limited opportunities to promote people's independence. We did see some people were helped to make a sandwich and a drink. However, we saw that opportunities were very limited and often missed to assist people with developing their daily living skills and to involve people with day to day tasks.

We saw that care had not been taken to ensure that all people lived in a safe and comfortable environment. Some people bedrooms had not been well maintained. We saw that some people did not have curtains or blinds on their windows to ensure that their privacy was maintained. Where adjustments where needed to the environment to respond to a high level of wear and tear and to ensure facilities were fit for purpose these had not been made. We did however see one person's bedroom that was personalised and well

equipped and the person had many personal items and told us "I love my bedroom".

People could not be confident that their views would always be listened to and acted on. We saw that residents meetings in Ascot unit had not taken place for several months and there were no records of meetings with people in Beverley unit available for us to see and staff were unsure when the last meeting had taken place.
We found that people were not receiving a service that was personalised for them. The provider was not consistently working in partnership with all people to support people to make informed decisions about their care.

We found that the evidence above supports that the provider was in breach of regulation 9. Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person – Centred Care.

Requires Improvement

Is the service responsive?

Our findings

Some people had difficulty expressing their needs and wishes verbally about what they would like to do. We saw that the lounge in Beverley unit was bare and functional. There were no pictures, photographs or activities for people to engage with to spark conversation. There was no evidence of people's personal hobbies or interests apart from one person who occupied themselves for long periods of time with colouring pens and paper and this was something that they clearly enjoyed doing. We saw that the only information displayed in the lounge was staff notices and staff information.

We looked to see how people were supported to follow their interests and take part in social activities. We saw that people were not always involved in planning their own activities and how they spent their time. For example, on the first day of our inspection we saw people sitting for long periods of time with no engagement from staff and no stimulation in the environment apart from a television. Some people looked bored. On the second day of the inspection we heard staff discussing that they were going out with some people to the cinema. Staff discussed the arrangements amongst themselves. When we asked what film people were going to see a staff member told us that they would decide when they got to the cinema. We heard one person say quite clearly to a staff member that they did not want to go to the cinema because they were tired from the trip out the day before and they were going to stay at home and write on Christmas cards. Another staff member came into the lounge and told the person to get their coat from their bedroom because they were going out. The choice expressed not to take part was not accepted or discussed as an option. People told us and records showed that people did go out to local shops, parks and places of interest and the day in between our visits most people had gone on a trip out together to Blackpool. However, it was unclear how activities and trips were planned and records looked at did not reflect people's response to activities they had taken part in which would help to inform future planning.

Information was not always communicated effectively within the staff group on a daily basis to ensure that people were supported by staff who understand their current needs and risks. Staff told us that a handover took place at the start of a shift. However, we were made aware of an incident that had taken place the day before, a person living at the service told us about it. When we asked the senior staff member on duty about this they were unaware of the incident. The staff member confirmed to us later in the day that what we had been told by the person living at the service was accurate and they [Staff member] had been unaware of the incident.

Staff's knowledge about people's needs was variable some staff had good knowledge and some staff's knowledge was limited. For example we asked a staff member about a person's visual impairment and how this impacted on their day to day living. They were unsure about this however, they did refer to the person's records to check the information. Some people had a sensory impairment and we saw that no consideration had been given to how the environment could be adapted to meet this need and we saw no care plan in place to tell staff how they should support the person to meet this need. The care plans and risk assessments we saw were not person centred and had not always been kept up to date. Some people had been involved and consulted with about the writing of their care plan but we found that this was not consistent across the service.

People were supported to maintain relationships that were important to them. One person told us, "I keep in contact with my family. I talk to them on the phone and I see them every fortnight". We saw during our inspection that a person's relative was made welcome at the home. Staff told us that they recognised the importance of social contact. They supported people to maintain friendships and relationships and staff confirmed that people's relatives were welcome to visit the service.

People told us they were free to practice their faith and religion as they wished however the people we spoke with had not expressed a wish to go to any place of worship. We saw that one person was supported with meeting their religious needs within their own bedroom within the home as recorded in their care records.

The provider had information about how to make a complaint however we did not see that this was provided in an accessible format that people living at the service could easily understand. One person told us," If I had something on my mind that I was worried about I would tell the staff". Staff told us that some people would not be able to make a complaint but would be reliant on them or a family member to raise concerns on the person's behalf. They told us that they monitored people closely to observe for any signs that a person was unhappy about something and they would let the manager know their concerns. Staff told us that there had been no recent concerns or complaints raised by or on behalf of people using the service.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had failed to maintain an oversight of the quality of the care people received. We saw that there were systems in place to monitor the quality of the service, and quality audits were undertaken. However, these had not been effective at identifying the shortfalls in the service that were identified during our inspection. We found multiple breaches of the regulations. Where risks were identified the provider did not have measures in place to minimise, reduce or remove the risk. Medicine management was not always provided in a safe way. Recruitment procedures were not robustly followed. Maintenance issues had not been identified and resolved in a timely manner. Staff had not received all the appropriate training and support to carry out their role and the effectiveness of staff training had not been monitored. People were not always treated with dignity and respect and the provider had not ensured that people received person centred care. We found that record keeping processes needed improvement. Care records were not always kept up to date with changes in people's care need. Clear and accurate record in relation to accidents and incidents was not established. Records did not always reflect the care that people had received and people's response to care. We found that the evidence above supports that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was also the regional service manager for the provider. They had registered as the manager for this and another service owned by the provider when the registered manager's positions were vacant for a protracted time. They told us that they spent their time between the two services. They told us that the service had experienced a difficult time with the previous registered manager leaving and significant staff changes and that they were in the process of ensuring a more stable work force was in place. They told us that many of the staff that had left had not been suitable for the role. They told us that they would take action to make the improvements needed and to ensure that the service complied with the regulations. Shortly after our inspection they told us that a new manager had been appointed for the service and would be applying to CQC for registration.

The registered manager shared with us their aims and objectives for the service and explained that they were in a transitional stage. They explained to us that Ascot unit provided a service to people with very complex needs and that this was the direction that the service was moving in. We did not get a sense of a clear vision for the development of the service. We saw that the leadership of the service was not always effective, for example the registered manager had identified that supervision of staff needed to improve and had planned to address this but at the time of the inspection had not taken steps to do so. There were some pockets of positive practice that we saw and were told about. However, this was not a service that was person- centred, open and inclusive. We did not get a sense that the people who lived there were at the centre of this service and saw that engagement with people was often poor.

The local authority had shared their concerns with us prior to our inspection so we brought forward our inspection of this service. We saw that some recent internal investigations had taken place and the provider shared their findings with us. The provider told us that all investigations that had been requested by the local authority had been completed. They told us that although systems were in place for the recording incidents they had not developed their systems to capture and demonstrate how learning took place and

action taken to reduce incidents. Some people that lived at the service had behaviour management strategies that included the use of restraint. We asked the registered manager about how they could demonstrate to us that they were reducing the need for restrictive interventions (In line with Department of Health Guidelines Positive & Proactive care). They told us that they were not yet in a position to be able to provide this information.

We spoke to four professionals who have contact with the service. Some professionals told us about some good practice examples. For example the one professional spoke with us about the good rapport between the deputy manager and one of the people who used the service. However, some shared with us that communication was not always good from the service and that people had on occasions missed appointments with healthcare professionals.

Staff we spoke with told us that they felt supported in their work. Staff told us that there had been a lot of staff changes at the service and that things were starting to improve. They told us that they would speak with the deputy manager or registered manager if they had any concerns and they felt confident about doing this. They told us that they were aware of the whistle-blowing policy. (This is a term used when staff can raise a concern confidentially about people's safety). Staff told us that they had no concerns about the care of people using the service. Staff meetings provide an opportunity to encourage open communication and question practice. Staff told us that meeting were infrequent. Records we saw confirmed this.

Information we hold about the service showed us that the provider had ensured that information they were legally obliged to tell us had been passed on to us. We asked for information during and following our inspection and this was provided to us in a timely way.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people were receiving a service that was personalised for them. The provider was not consistently working in partnership with all people to support people to make informed decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that the systems and processes in place ensured that medicines would always be administered accurately and safely and that the premises used by the service provider were always safe for their intended purpose and maintained in a way that ensured people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that arrangements in place ensured that systems were followed to ensure that staff recruited were suitable.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain an oversight of the quality of the care people received. There were systems in place to monitor the quality of the service, and quality audits were undertaken. However, these had not been effective at identifying the shortfalls in the service that were identified.

The enforcement action we took:

Warning notice