Care Quality Commission

Shanti Healthcare Limited

Kestrel House

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We inspected Kestrel House on 14 & 16 October 2015. This was an unannounced inspection. At our last inspection on 7 May 2013 the service was not compliant with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. During our last inspection the provider was not meeting the legal requirement in relation to care and welfare. Previous to September 2015 the service was incorrectly stated to be registered as Brian Holiday when it was in fact Shanti Healthcare Limited.

Kestrel House is registered to provide care for up to 19 adults with mental health needs. At the time of inspection there were 17 people living at the home.

There was a registered manager at the service 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.

People told us they felt safe however records showed that safeguarding incidents were not always reported on to the relevant authorities. Risk assessments were not robust and did not provide sufficient detail to mitigate risks identified. There were inconsistencies in how risks were managed and this put people at risk of harm.

Summary of findings

Care was not always planned and provided in response to people's needs. Care plans were out of date and not tailored to the needs of each person, leaving them at risk of unsafe or inappropriate care.

Medicines were not effectively managed and did not have a clear audit trail so people were at risk of harm from receiving the wrong medication. We saw that medicines had not been appropriately signed for on the Medicine Administration Record (MAR) and that stocks of medicines could not be accounted for. Some people had not received their medicines as prescribed.

The provider was not meeting the requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and had not followed the appropriate procedures to act in people's best interests.

People were not always provided with appropriate food and nutrition. People requiring special diets for weight loss were not always identified within their care plans and there was no recorded meal planning to ensure they received the right balanced diet.

Care files did not contain life histories or information about the interests and aspirations of people using the service. People had mixed views being involved with their care plan. All the care files we saw had similar phrases and information about the care to be provided, with limited personal information. People's care files had three monthly reviews however the service did not monitor and evaluate all goals set up in people's care plans.

There were no effective systems for monitoring and auditing the quality of care and the service.

The registered manager had not notified CQC of any safeguarding incidents or other statutory notifications as required.

Staff received training and one to one supervision. People were able to make choices about most aspects of their daily lives. People were provided with a choice of food and drink. People had access to health care professionals.

People and their relatives told us they liked the staff. Staff had a good understanding of how to promote people's dignity.

We found seven breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not safely managed, with medicines not being recorded properly and stocks not accounted for. Some people did not receive their medicines on time.

Risk assessments were not robust and did not provide the information needed to keep people safe. People told us they felt safe however records showed that safeguarding incidents were not always reported on to the relevant authorities.

We found that staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

Is the service effective?

Requires improvement

The service was not always effective. The provider was not meeting the requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005. The provider had not obtained appropriate authorisation to deprive people of their liberty, and people may have been deprived of their liberty unlawfully.

People requiring special diets for weight loss were not always identified within their care plans and there was no recorded meal planning to ensure they received the right balanced diet.

Staff undertook regular training and had one to one supervision meetings. People had access to health care professionals.

Is the service caring?

Inadequate

The service was not caring. Care plans were not personalised and did not meet individual people's needs. There were no life histories or information about personal preferences, with care plans being generalised and some containing incorrect personal information.

People had mixed views about being involved in planning and making decisions about their care and support

Staff respected people's privacy and dignity. They always knocked and called people's names before entering their rooms and respected their wishes.

Is the service responsive?

Inadequate

The service was not responsive. People did not receive personalised care that was responsive to their needs as care plans lacked detail and were not updated to reflect changing needs or preferences.

People had opportunities to engage in a range of social events and activities according to their choices.

People knew how to make a complaint if they were unhappy about the service.

Summary of findings

Is the service well-led?

The service was not well-led. There were no effective systems for monitoring and auditing the quality of care and the service.

The registered manager had not notified CQC of any safeguarding incidents or other statutory notifications as required.

Inadequate

Kestrel 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we checked the information we held about the service. This included any notifications and safeguarding alerts. We also contacted the local borough contracts and commissioning teams that had placements at the home, the local Healthwatch and the local borough safeguarding team.

The inspection team consisted of two inspectors, a mental health specialist, a pharmacist and an expert by experience, who had experience with people with mental health conditions. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We spoke with seven people who lived in the service and one relative during the inspection. We spoke with the registered manager, the deputy manager, two senior support workers, one support worker and the chef. We also spoke to two visiting health professionals during the inspection. We looked at 10 care files, staff duty rosters, five staff files, a range of audits, minutes for various meetings, medicines records, finances records, accidents and incidents, training information, safeguarding information, health and safety folder, and policies and procedures for the service.

Inadequate

Is the service safe?

Our findings

The service was not safe. We saw that medicines were in stock and available for people. Medicines were stored securely, however temporary arrangements had to be made when the monthly order was delivered as the clinic room was not large enough to store the extra medicines. Medicines were in date and suitable for use, however eye drops had not been dated when opened so they may reach their expiry date without staff being aware. People came to the clinic room to receive their medicines and staff administered the medicines in a safe and caring manner, taking time to talk to people and allowing them to take their medicines in the way they preferred. A record was made of all medicines administered at the time and any refusals were noted. We saw that one person was refusing their medicines quite regularly and we were told that the GP was aware of the situation and the person was under regular review.

The medication administration records (MAR) were printed by the pharmacy and any changes or additions were written by staff. There was no system of double signing or checking to ensure that these additions were accurate.

Records showed that two people were currently self-medicating and stored their medicines in their room. There was no risk assessment or care plan in place for either of these people to support self-medication and no reviews to check that it was safe. We were told that one person had been doing this for some time and that staff were unable to check their medicines, and the second person had returned from a period of leave and not returned the medicines to the staff. The medicines policy for the service states that a self-medication assessment must be done, however this process had not been followed for either of these people. The medicines policy did not inform staff as to the safe way to record medicines given to people when they went on leave and we saw that no record of this had been made. This meant people not being reviewed and assessed for medicines, were at risk.

Some people were prescribed injections that were administered by the GP surgery at two weekly intervals. We saw that one person had not received their injection for six days past the due date and no appointment had yet been made at the surgery. For this person, this meant that their medicine was not being administered in a timely manner and could negatively impact on their health.

Staff had a system of checking and auditing medicines that were not supplied in blister packs daily. We saw that these were completed, however where discrepancies were shown there was no action recorded as to why this had happened. We checked some medicines and found one that was incorrect that was recorded as correct. This showed that one person may not have received their medicines as prescribed. We were told that training sessions had been arranged with the pharmacist for the two days following our visit.

People's care was not always planned in response to their needs. Care files contained risk assessments but these did not always cover known risks to people and how these were to be managed. For example, one person had been assessed at risk of falls when bathing and showering. However the care plan in place gave no specific guidance and information on how this was to be managed. The same person had been assessed to have challenging and violent behaviour when feeling unwell. The care plan stated that periods of increased stress could be a trigger but did not clearly explain what could lead to the person becoming distressed.

Another person's risk assessment highlighted that they were vulnerable to sexual abuse and victimisation. This was not referred to within in the care plan and no further guidance was provided for staff on how to support this person, placing them at risk of harm and abuse.

We noted that one person had a fall in January and April of this year. The service last completed a risk assessment for this person in January 2015 and the last care plan for July 2015 and had not highlighted any concerns with falls. We spoke to the registered manager about actions they took regarding this person's falls. The registered manager responded, "Do you think we should have done a risk assessment"? The inconsistencies in risk assessments means there is a risk that people do not received safe support.

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

People told us that they felt safe using the service. One person told us "Yes I feel safe and comfortable here." Another person answered "Yes" when asked if they felt safe. A relative told us, "[Relative] is safe and that is all that matters to me."

Inadequate

Is the service safe?

The service had a safeguarding adults procedure in place. This made clear their responsibility for reporting any allegation of abuse to the relevant local authority and the Care Quality Commission. The service also had a copy of the host local authority safeguarding adults procedure to refer to if required. We saw posters with contact details for the local authority for reporting any issues of concern were on display. Staff told us they had received training in safeguarding adults and records confirmed this. The service had a whistleblowing procedure in place which made clear staff had the right to whistle blow to outside agencies if appropriate. Senior staff and support workers we spoke with had a good understanding of issues related to safeguarding adults and whistleblowing. One staff member told us, "I would report to the manager." Another staff member said, "I would whistle blow and get social services involved if nothing done." However, records showed two recorded incidents of people who used the service being physically attacked. These incidents had not been reported to the local safeguarding authority. Incidents of violence and aggression towards and between people who use services should be reported to local authorities to investigate under local safeguarding adults procedures. This placed people at risk as safety was not reported to the relevant authorities.

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

The premises were well maintained and the provider had completed all of the necessary safety checks and audits. We saw that fire safety checks and drills were done regularly. Fridge temperature checks, portable appliance testing and gas safety inspections were carried out at appropriate intervals to ensure people's safety.

Financial records did not show any discrepancies in the record keeping. The home kept accurate records of any money that was given to people and kept receipts of items that were bought. Financial records were checked and we saw records of this. After the inspection we spoke with a local authority who were appointees for four people living at the home. They told us the home's financial records were well managed and had no concerns. This minimised the chances of financial abuse occurring.

The service had a robust staff recruitment system. We saw that appropriate checks were carried out before staff began work. Staff files showed that two references were obtained and criminal records checks were carried out to check that staff are suitable to work with vulnerable people. This assured the provider that employees were of good character and had the qualifications, skills and experience to support people living at the home.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. The provider was not meeting the requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005. A senior staff member told us one person had been authorised for DoLS however it had expired on 17 August 2015. A senior staff member told us they had applied to renew the DoLS application on 8 October 2015 which meant the person was illegally deprived of their liberty for over six weeks. A best interest assessor visited on the first day of our inspection to renew the person's DoLS application. This meant staff did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

The service had a policy on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. However there was no specific guidance in the policies, which mostly consisted of photocopies of the guidance from a national mental health charity. The DoLS policy contained no guidance to staff and no contact details for services if a mental health act assessment was needed. Staff had undertaken training on MCA and DoLS however staff told us the training went for two hours. One staff member said about the training, "I came away thinking I didn't understand that fully." This meant staff were not supported to have an understanding of their responsibilities regarding Mental Capacity Act and Deprivation of Liberty safeguards.

The above issues were a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files contained individual care plans, risk assessment, nutritional risk assessment and contingency plans. The nutrition risk assessments were not detailed and had minimal information about the nutritional requirements of each person. For example, one person who was identified as being overweight had a nutritional risk assessment that stated "eating habits to be observed and documented daily." However, there was no documentation to monitor food intake for this person. Another example, one person had been identified as overweight and the nutritional risk assessment stated "a well balanced diet is to be implemented consisting of low calories" however there was no recorded evidence this had been implemented. All the care plans we looked at stated food and fluid intake was to be monitored and recorded, however this was not being recorded in people's individual care files or daily records.

The above issues were a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food and that they had choices of meals. One person said, "The food is alright and I do get a choice." The chef told us people are asked their choices the night before and we saw records of this. We saw the menu included traditional foods that reflected the cultural and ethnic backgrounds of people that used the service. We saw that a selection of juices and water were always available in the lounge area and people could help themselves. People could also use the kitchen to make their own hot drinks with staff supervision.

People and their relatives told us the staff were very good and supported them well. One person said, "The staff are alright. They do a good job." Another person told us, "The staff always help me if I need anything." One relative commented, "I like the staff. They are friendly and they talk to you."

Staff told us they received regular training to support them do their job. One staff member told us, "There is enough training to support us." Another staff member said, "We requested more medication training and it was arranged for us." The training included health and safety, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), food hygiene, manual handling, fire safety, infection control, safeguarding adults, medicines, communication and mental health. On the day of our inspection we saw training being conducted on understanding mental health and aggression.

Staff received monthly formal supervision and we saw records to confirm this. One staff member said, "The manager will ask about the residents and if I am happy with the training." Another staff member told us, "I get supervision every four to six weeks." All staff we spoke with confirmed they received yearly appraisals and we saw documentation of this. The registered manager told us they gave supervision to all the staff at the service. Records showed topics on performance, communication, interaction with service users, timekeeping, working with others, sickness and any issues and concerns.

Requires improvement

Is the service effective?

People said they had support with health appointments. One person told us “I see my GP.” Another person said, “If I have a toothache I will ask them [staff] to sort.” Records showed that people had routine access to health care professionals including GP’s, dentists, opticians, psychiatrists and occupational health. People were supported to attend annual health checks with their GP and records of these visits were seen in people’s files.

Inadequate

Is the service caring?

Our findings

The service was not caring. People had mixed views about being involved in planning and making decisions about their care and support. One person told us “I do not have a care plan.” The same person said, “I am not involved in making decisions about my care.” Another person told us “I don’t have a care plan.” However one person told us, “I am involved in my care plan. They [staff] tell you what is going on.” Another person said, “They always read up on your care plan and know what support you need. They always involve me in what care I need.”

People and their relatives told us they thought that the service was caring and they were treated with dignity and respect. One person told us, “They [staff] are kind and nice." Another person said, “I have the same people caring for me and they know me as a person.”

The care files we reviewed did not contain life histories or information about the interests and aspirations of people using the service. All care files we looked at stated, “[Person] requires ongoing rehabilitation and encouragement to meet agreed targets and goals” but did not state what these were or how they were to be achieved. One person told us, “The staff try to support me to be independent but they don't act on this.” One staff member said about the care files, “Personally they need to be a little more person centred.” The same staff member told us, “I struggle to relate to the format at the moment.”

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

People could choose where to spend their time during the day. Some people chose to remain in their rooms, while others told us they liked to be in the communal areas with other people. One person said, “Yes you have choices. You can stay in or you can go out when you want.” Another person told us, “I have a choice about what I want to do.” This meant that people had choices about where they spent their time during the day.

Staff respect people’s privacy and dignity. We spoke with staff members about this, and they told us how they respect people’s wishes. One staff member told us, “If something to say I will call in the office and close the door.” The same staff member said, “I will ask permission when I go into their room.” This was confirmed by people using the service. One person told us, “They let me have my privacy.” Another person said, “The staff always try to ensure my privacy and dignity.”

Relatives were able to visit at any time, and could bring in food and any other items people wanted to decorate their rooms with. This meant people had the opportunity to personalise their own rooms and have what they wanted and could maintain regular contact with their families.

Inadequate

Is the service responsive?

Our findings

The service was not responsive. All the care files we looked at had similar phrases and information about the care to be provided, with limited personal information. The files omitted important information, including hospital admission, police incidents, violence and behaviours that challenged the service. For example, one person had been physically assaulted on 3 April 2015 however this was not identified in the care plan dated the following day and subsequent care plan reviews. This means that care was not tailored to individual needs and that people are at risk of inappropriate care and support.

Daily reports were only completed at 8pm each day by the night staff, and therefore did not reflect the whole day and often excluded important information that would affect how care should be provided and changes in support needs for people. For example, the accident and incident log reported that one person had been physically assaulted by another person living at the service however this was not documented in the daily report. We saw care plans stated that mental states were to be documented on each shift, but this was not done in either the daily report or the care plan. This meant that care was not being delivered in accordance with the care plans, putting people using the service at risk from inappropriate care.

The care plans we reviewed listed diagnosed conditions and medicines, but did not contain other personal information, life histories or details of people's preferences. For example, one person had been diagnosed with epilepsy however the care plan gave no guidance how to recognise a seizure and if/when to call emergency services. This means that care was not tailored to the requirements of each individual person and could result in poor standards of care being given.

People's care files had three monthly reviews however the service did not monitor and evaluate all goals set up in people's care plans. For example, one person's goals on their care plan included achieving weight loss. However, the three monthly reviews provided no relevant information about the person's progress. The person's care plan included a specific exercise goal that staff were to document on a daily basis however the reviews did not refer to this either. This failed to reassess the person's needs and preferences so as to monitor progress and redesign care as needed.

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

The service provided a basic range of activities which were displayed on the noticeboard however these were dated for the previous month. On both of the days we visited the service, we observed that people took part activities such as board games, puzzles and newspaper reading. One person told us, "We go to the cinema, park, and bowling every Wednesday. There is always an activity." Another resident told us, "They took me to the cinema." Records showed activities were discussed and agreed upon in regular resident meetings.

People were able to make suggestions and complaints about the service. We saw the complaints book that contained feedback from people using the service with their comments, and details of actions taken to address these issues. One person told us, "I feel comfortable about making a complaint. I could always approach the manger if I have any concerns." Another person said, "The management listen to us and supports our views."

Inadequate

Is the service well-led?

Our findings

The service was not well-led. In preparing for this inspection we looked at the information we already held about the service. We found the provider had not sent us any statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS). During the course of this inspection we found that one person had been authorised for DoLS and CQC had not been sent notification of this. We discussed this with the registered manager who said they were not aware that such incidents needed to be notified to CQC.

The service had six accidents and incidents since January 2015. One incident detailed a violent incident outside the home to a person using the service. The same person had another incident recorded where they had physically attacked another person living at the service. These incidents had not been reported to the CQC. Incidents of violence and aggression towards and between people who use services should be reported to local authorities to investigate under local safeguarding adults procedures. This placed people at risk as safety is not effectively monitored and reported to the relevant authorities.

The above issues were a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was no system for effectively auditing records, care plans and risk assessments. We reviewed ten care files that included three monthly reviews which had no actions from them and the care plans and risk assessments remained the same. These care records included significant omissions of people's care including details of major illnesses and criminal convictions that were not detailed in care plans and risk assessments. These could have a significant impact on the care and welfare of people using the service.

The registered manager showed us a blank quality assurance template for people to complete, however when we asked for completed copies the service was unable to produce any. The service had given people a survey on activities and we saw records of these, however these had not been analysed.

The provider's policy on quality management stated the service would have an annual development plan drawn up as part of its business plan based upon feedback from service users, staff and relatives. The policy also stated that the registered manager was responsible for quality in the home and the deputy manager was responsible for distributing annual surveys. The registered manager told us he assessed the quality of the service through staff supervision, reviewing records and room checks however the registered manager was unable to produce any documentation and evidence for these quality checks. This meant there was no effective system in place to audit these records and ensure improvements were made and maintained.

These issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in place. Staff told us they found the registered manager to be helpful and supportive. One staff member said, "He is fair. We can discuss anything." Another staff member said, "I think [registered manager] is a good manager. He listens and very approachable."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 11 HSCA (RA) Regulations 2014 Need for consent **The consent of people who used the service was not always sought.**

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 **People who used the service were not safeguarded against the risks of abuse because the provider had not responded appropriately to allegations of abuse. Regulation 13 (1) (2) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People who use the service were not always protected from the risk of inadequate nutrition and dehydration by means of the provision of support. The provider was not always meeting the requirements of food and hydration arising from the people's preferences. Regulation 14 (1) (2) (b)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for people. People were not protected against the risks of receiving care that was inappropriate or unsafe because care was not planned and delivered to meet their individual needs or ensure their safety and welfare. People's health and wellbeing was at risk because of unsafe practices at the service regarding the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. Regulation 9 (1) (a) (b) (c)

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used the service were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems and records, designed to enable the registered provider to regularly assess and monitor the quality of the service provided. Regulation 17 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Care Quality Commission about statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS), any abuse or allegation in relation to a service user and any incident which is reported or investigated by the police. Regulation 18 (1) (2) (e) (f) (4) (a)

The enforcement action we took:
We have judged that this had a minor impact on people who use the service. This is being followed up and we will report on any action when it is complete.