John-Edwards Care Homes Ltd

Bobbins

Inspection report

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15 February 2019

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Bobbins is a residential home providing care to young adults with learning disabilities. The accommodation is a detached house in the town of Swindon. There is a parking area in front of the building secured by electric gates and an enclosed garden at the rear. The home is registered to provide care for up to six people. There were six people living in the home at the time of our visit.

People's experience of using this service:
People were unsafe due to risks not being managed effectively. Where risks were identified clear guidance on how to manage these risks was not available to staff. Staff told us they sometimes did not feel safe.

Accidents and incidents were not always investigated or used as an opportunity for learning and to prevent future reoccurrence. Staff understood their responsibilities in relation to safeguarding, but safeguarding incidents were not always fully investigated and recorded.

Medicines were not always kept secure.

The environment was not always clean or safe for people using the service and all environmental risk assessments were out of date.

Consent forms were signed by people's relatives who had no legal rights to do so.

Some people had no opportunity to engage in activities outside of the service.

The provider did not have effective systems in place to monitor the quality of the service they provided or to drive improvements where needed. Some records were not always available, accurate or complete.

People were treated with kindness and respect. People's right to privacy and confidentiality was respected. People were all involved in making decisions about the premises and environment, regardless of their ability to communicate.

Rating at last inspection:
Good (Last report published 25 March 2017).

Why we inspected:
This inspection was brought forward in response to incidents that had occurred at the service and concerns that had been raised about the safety and management of the service.

Enforcement:
Please see the 'action we have told the provider to take' section towards the end of the report.

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Following the inspection we referred our concerns to the local authority responsible for safeguarding. In addition, we requested an action plan and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Bobbins

Detailed findings

Background to this inspection

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

Inspection team:
Two inspectors and one expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses care services. In this instance, services for people with a learning disability.

Service and service type:
Bobbins is a care home. People in care homes receive accommodation and nursing or personal care. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was run by a regional manager who was to become registered with the Care Quality Commission (CQC).

Notice of inspection:
This inspection took place on 13 and 15 February 2019. The first day of the inspection was unannounced.

What we did:
Before our inspection visit, the provider completed a Provider Information Return (PIR). We used this as part of our planning. The (PIR) is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important

events, which the provider is required to send us by law.

We asked the local authority for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people's care and monitoring its quality.

This inspection included speaking with four people's relatives, five staff members, the regional manager and the clinical lead. We also reviewed records relating to the care of four people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, four staff files and the staff duty rota for the last eight weeks. We also looked at documentation relating to the safety and suitability of the service. We were unable to communicate verbally with most of the people due to the complex nature of their needs; however, we observed how staff interacted with the people who lived in the home.

After the inspection we requested further information from the regional manager and the provider. Not all of the information was received: For example, we have not received an incident form or records of an investigation of unexplained bruising.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not complied with.

Using medicines safely

● Guidance for 'as needed' medicines (PRN) was unclear. We saw an undated protocol for a medicine that may be required in an emergency. The guidance in this protocol did not accurately reflect the actions that should be taken by staff in the event of an emergency. For example, the first step of the guidance was to observe the person when the first step should have been to administer medicines and call an ambulance immediately. The inaccuracy of the PRN could pose a significant risk to the person due to staff not having clear guidance in the event of an emergency.

● Medicines were not kept securely to avoid accidental access. On arrival at the service, we noted that the medicines room was unlocked as a staff member entered the room without using the keypad. When we visited the medicines room, we saw that the keys were in the lock on the medicines cabinet. This meant that any staff or people in the service could access the medicines if they were able to enter the room. The manager removed the keys after we commented on this. It was clearly stated in risk assessments that 'Medication in the home is locked away in a medication cabinet and the cabinet is locked in the utility room. The keys are kept in the office when it isn't medication time. The office is locked when no-one is in the room'.

● The storage of medicines was not always safe. Where records indicated the daily temperature checks had exceeded the maximum safe temperature, there was no action recorded to explain measures taken to ensure safe storage of medicines. Storing medicines at temperatures outside the manufacturer's guidance meant they may not remain as effective as intended.

Preventing and controlling infection

● There were no facilities for the safe storage and disposal of clinical waste at Bobbins. We asked a member of staff how they disposed clinical waste. The member of staff told us, "We don't have a healthcare waste bin. We just put used pads into a regular bin outside".

● Staff were clear about the need to use personal protective equipment when providing personal care.

Learning lessons when things go wrong

● There were systems to review incidents or accidents to see if any further action was needed and to minimise the risk of reoccurrence. However, not all incidents were appropriately investigated or included into an accidents summary for each month. This meant that some trends and patterns could be left unidentified and unaddressed.

Systems and processes to safeguard people from the risk of abuse

● People were at risk of avoidable harm. Where risks had been identified, management plans were not clear or coordinated and the monitoring of these were ineffective. Risk assessments for a person with epilepsy did

not contain sufficient information in relation to all areas of risk that needed monitoring. For example, there was no mention of risks regarding areas such as bathing; travel; activities; eating and drinking and activities. The risk assessments that were included in this persons' file were undated so it was unclear if they were up-to-date or outdated. However, we saw that the regional manager had signed to say that the support plan and risks assessments had been reviewed and were still relevant on 31 January 2019. The monitoring and management of the risks had not identified that the epilepsy guidance was not in line with NICE guidance.

● There were Personal Emergency Evacuation Plans (PEEPS) in place. These are individual 'escape plans' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. PEEPS should detail a step by step evacuation procedure to clearly explain what assistance the person would need. We reviewed people's PEEPS which were unclear and potentially putting people at risk. For example, the advice about the person requiring assistance was halfway down the second page and stated full assistance was needed to assist the person to evacuate safely. It did not detail the method of assistance, lacked advice about the person's communication method, and did not include information about potential behaviour that may affect safe evacuation. Another person's PEEP stated that as the person may need to be manually transferred to a wheelchair, it depended on staff whether they would decide to evacuate the person or not. A member of staff told us, "I have had fire training. For [person] it is our choice and one of these options is to carry [person] out. More clarity about emergency evacuation procedures is needed". This meant staff were not provided with clear guidance in case of an emergency which could put people and staff at risk.

● Before our inspection we received concerns regarding staff not being trained in any intervention technique. Staff told us they did not always feel safe as they were not allowed to use physical restraint as a last resort. There had been a recent incident when an agency member of staff had got injured by a person and had to call for an ambulance after locking themselves in the office. A member of staff told us, "Although it is better than it was, I still do not feel very safe at work". All the members of staff we spoke with explained to us they were not allowed to use physical restraint as they were told it was not in line with the company policy. We looked at the policy which stated, "Where necessary, reasonable force can be used to control and restrain those at risk or posing a risk to others". This meant that staff were unaware of 'The use of physical interventions by staff' policy and put themselves and other people at risk by not being able to use physical intervention.

● According to the Positive Behaviour Support (PBS) plan, no physical intervention was considered for a service user who displayed challenging and sexualised behaviour. This person had a history of physically assaulting staff and targeting female staff and people using the service. Staff were advised to go in pairs to the person's room and to be always near the door. However, the PBS plan did not provide staff with any information on what to do if another member of staff, another person or a visitor were physically assaulted by the person. This meant staff did not have sufficient guidance to protect themselves, people living at Bobbins or visitors. The person's hospital passport did not mention significant information about their past, which might put hospital staff, patients and visitors at risk.

This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not safeguarded from the risk of abuse. Safeguarding notifications received by the Care Quality Commission described incidents but did not include any detail of actions taken to prevent future occurrences. The records held at the service were not always clear on what action had been taken to prevent the reoccurrence of incidents. Some incidents of unexplained bruising were not always investigated by the service. For example, we found a few body maps with unexplained bruising recorded, however, there was no evidence whether it had been investigated by the service. There was no accident/incident report after one person physically assaulted an agency member of staff.

● The service did not always ensure that assessments were carried out where professionals had advised a need for it. For example, professionals suggested a forensic assessment was required to fully understand one person's needs and risks as the person was reaching adulthood. There was no evidence of such an assessment carried out and the regional manager was unaware this had been suggested by professionals. The person in question presented a risk to others as the person was known to have displayed sexualised behaviour.
● One person's relative told us they had reported unexplained bruising of the person to the service. On the day of the inspection we could not find any documentation relating to any investigation of the incident, however, the message about the unexplained bruising from the relative had been recorded in the message book. The person's relative told us that the service had failed to liaise with them to explain the bruising. The regional manager told us they had investigated the incident and spoke to the person's relative, however, there was no evidence to support this.

This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider had been reliant on a high number of agency staff in the seven months since they had taken over the service. The regional manager told us they now had adequate numbers of permanent staff and would not be requiring agency staff next month. We saw that checks to ensure staff were safe to work in the service had taken place. These included DBS and other recruitment checks such as references carried out.
● There were enough staff available to allow people to access the community and to have their personal needs met on both days of our inspection. However, we noted that people's needs had not always been reflected in appropriate staffing levels in the last eight weeks. For example, rotas showed inadequate staffing cover over the Christmas period of time.

Assessing risk, safety monitoring and management
● All environmental risk assessments (washing floors, service users accessing medicines or cleaning products, use of electric gates/key pad doors, using stairs) had not been regularly reviewed.
● People were at risk of harm as the physical environment at Bobbins was, in places, in a poor state of repair. For example, all radiator covers on the ground floor were broken, some of these had sharp edges, which people could injure themselves on.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● People's human and legal rights were not always understood and respected. Consent forms for three service users were signed by relatives who did not have the lasting power of attorney.
● There was a best interest meeting organised for one person regarding measles vaccination. However, there was no evidence of any health professionals or the person being involved in this process. Only the manager and the deputy manager participated in the meeting. It is not clear what options were discussed and what led to this decision.

This constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where required appropriate applications had been made to deprive people of the liberty within the law.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support did not reflect current evidence-based guidance and best practice. We saw that people who had behaviours that challenged had not been fully assessed to minimise any risks and to promote their quality of life. We saw a person had a Positive Behaviour Support plan but this did not describe certain factors, such as whether the person had autism and what communication difficulties may be present. There was also no use of visual supports to provide structure and routine, reduce anxiety and improve understanding. We discussed this with the regional manager who told us that the autism team were working with the person and they had discussed ways of managing the behaviours and had obtained some

timers to implement time concept for people. The local authority autism team had been involved since November 2018 and were in the process of developing other ways to help manage behaviours. However, we found that people were being restricted from accessing activities of their choice due to their behaviours not being managed effectively.

Staff support: induction, training, skills and experience

● Staff supervision and support were not always consistent and did not always meet staff's needs. Supervision was not always conducted in line with the provider's policy. The service did not have a consistent approach to supporting staff to maintain their professional skills or knowledge of best practice. A member of staff told us, "There was very little in the way in induction and no training until a couple of months after starting. However, there were lots of agency staff and the situation is now improving".

● We noted that more than a half of the staff employed by the service had not received training in Control of Substances Hazardous to Health (COSHH), lone working, managing continence, nutrition and hydration or safeguarding.

● Most of the staff we spoke with felt supported by the service. A member of staff told us, "I feel supported all the time. I have opportunity to raise my voice during supervision. I can approach my manager directly she is on call all the time".

Supporting people to eat and drink enough to maintain a balanced diet

● We found people were offered healthy food and a balanced diet. However, there were gaps in people's monthly weight monitoring charts which meant people's fluctuating nutritional needs could not always be updated to reflect their current nutritional needs.

Staff working with other agencies to provide consistent, effective, timely care

● Staff members passed information between themselves as part of structured handovers at the end of one shift and the start of the next. This information contained details about the person and the support they had received and any medical or personal issues which still needed to be considered.

● There was a message book in the service where staff recorded important information which was to be passed to other staff and the management. However, this was not clear if the important messages were read and if they were acted upon where necessary.

Adapting service, design, decoration to meet people's needs.

● We found the premises to be nicely decorated and in line with people's taste. Photographs of people and persons important to them were displayed in people's bedrooms. People were involved in choosing the décor of their rooms.

● One person had mobility difficulties. The service had adapted the premises by installing two ceiling hoists. We saw the ceiling hoist had been recently serviced and safe to use.

Supporting people to live healthier lives, access healthcare services and support.

● Prior to the inspection, we were informed about concerns that people were receiving medicines covertly which was not in line with the Mental Capacity Act 2005. We saw at this inspection that the service had taken action to ensure a capacity assessment and a best interest decision were made as required.

● People had hospital passports in place which could be shared with medical staff if the need arose. However, these were inaccurate, although they had been reviewed as still relevant. For example, the medicines on one person's passport were not all in use. This meant that the person could be at risk of receiving unsafe treatment in hospital.

● We saw that people had been supported to attend appointments with their GP's, opticians and dentists as necessary.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity
● Staff were not always provided with training and support to provide care and support people in a personal way.

● We observed staff treated people with kindness and respect. We witnessed many positive interactions between staff and people they supported.

● Not every person had their life history recorded. However, staff knew people's preferences and used this knowledge to care for them in the way they liked.

● People's relatives told us the quality of support had recently improved and they provided us with positive feedback about the staff approach. One person's relative told us, "He is getting the right care and support now because of [regional manager]".

Supporting people to express their views and be involved in making decisions about their care.
● Staff encouraged people to make choices in the way they received their care and people's choices were respected. A member of staff told us, "We actually help people to decorate their bedrooms. [Person] chose the colours to go with her bed. She went to the shop to make a choice. She chose the paint of the wall and bedding".

Respecting and promoting people's privacy, dignity and independence
● People's independence was not always promoted by the service. People were restricted because of the limited activities and limited outings they could be involved with.

● The provider recognised people's diversity. They had policies which highlighted the importance of treating everyone as individuals.

● The service ensured they maintained their responsibilities in line with the General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. Records were stored safely maintaining the confidentiality of the information recorded.

● Staff told us how they ensured people received the support they needed whilst maintaining their dignity and privacy. A member of staff explained to us, "When we give personal care, we need to respect their

dignity. For example, when we provide personal care and help someone to wash their body, other parts of the body must be covered. We respect preferences of our service users".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Some people had limited access to activities outside the service. Staff told us they recognised the issue of lack of activities provided to people. A member of staff told us, "This could be improved, particularly with [Person]".
- The service did not meet people's individual needs in relation to maintaining interests and hobbies, maintaining relationships or contact with the community. For example, we saw a person had two goals. One of them was reducing the use of a continent aid. We asked the regional manager if this goal was a true reflection of what the person may want. The response was that using continent pads compromised the person's dignity. However, there were no steps as to how this was to be achieved. We looked at a school review from January 2018 which had various ideas of goals such as accessing a hot tub and using symbol support. However, these suggestions had not be incorporated into the person's care plan in respect of their aspirations.
- We saw an activity planner for one person. This had limited information and had no symbols to explain the activities to the person. This mentioned college, baking, arts and crafts and personal care and medication. There were no activities planned outside of the home apart from college.
- Care records for one person were also contradictory. For example, an aspect of the person's behaviour was described as happy. We saw later in the care plan that the same kind of behaviour could be a sign that the person was agitated. This meant the person could be at risk of having their communication misinterpreted by staff.
- Outcome planners did not always reflect information included in people's care plans. For example, one person's care plan referred to the outcome planner stating that one of the person's goals was to increase their knowledge of foods. This was not mentioned in the person's outcome planner. There was no evidence that staff were supporting this person to increase their knowledge of foods.
- The service had not taken any steps to comply with the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.

This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where possible, people were involved in developing their care plans. Care plans did not contain enough details on people's individual needs. There was limited information about people's histories, past interests, preferred activities or aspirations.
- People's care needs had been reviewed but these were not accurate. We saw that the regional manager had reviewed a person's care plan and their risk assessment two weeks before the inspection stating no changes had been needed. However, we found the records held information that was incorrect and out of

date. This meant care plans did not sufficiently guide staff on people's current care and support needs.
● Some records were not always available, accurate or complete. We saw gaps in one person's weight chart, as well as gaps in people's daily logs. Some documents were updated but the updates were not reflected in people's care folders and staff had no access to them. For example, one person's positive behaviour support plan had been updated, allowing staff to use the break away technique, however, this was not mentioned in the person's folder. Other documents contained inaccurate information. One person's risk assessment had the name of a different location and it did not fully identify risk of sexual assault on a member of the public. Another person's hospital passport stated under the 'Moving around' section that 'I must hold hands with staff and use my special belt that keeps me safe from danger and safe from absconding'. We were told this had been removed from the service and was no longer used. Care plans were not always dated and we were not sure how current they were.
● The name of one person misspelled in the front of their care file. Using the name of a male service user in a female service user's folder.

This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns.
● The provider had systems in place to record, investigate and to respond to any complaints raised with them. However, these systems were not always effective. According to the provider's policy, verbal complaints were to be recorded and investigated and complainants were to be provided with answer in a timely manner. However, there was no evidence that all complaints raised by people's relatives over the phone had been recorded as a complaint and appropriately investigated.

End of life care and support.
● At the time of our inspection no one at the service was receiving end of life care. The service was a home to a group of young people, therefore discussing end of life care with young people would not be appropriate.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in the service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.

- Appropriate investigations did not always follow incidents and people's relatives were not always provided with information about the outcome of the investigation.
- Our inspection rating was not available on the provider's website or displayed in the premises. We brought this to the attention of the regional manager who displayed the rating in the premises on the second day of the inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- There was no registered manager in post. The service was run by the regional manager who was open and transparent about the quality of care provided to people. The regional manager realised the service needed improvements to comply with regulatory requirements.
- Staff we spoke to were knowledgeable about their roles within the service. They understood their role in peoples' lives, however, sometimes they felt left without clear guidance. For example, guidance regarding emergency evacuation or the use of physical restraint.

Continuous learning and improving care.

- The local authority had been working with the service in relation to recent concerns. An action plan created by the service in response to the concerns was not accurate. The action plan stated actions had been completed when they had not. For example, a hospital passport did not contain up-to-date information, and not all staff received supervision.
- The provider's quality assurance systems did not result in action to improve the service. The service was supposed to update all care plans onto new format by 26 November 2018, however, on the day of the inspection one person was still using their old care file.
- The new provider had been running the service for six months. There was no evidence that they had conducted a thorough assessment of the risks and the quality of care within the service and identified actions to improve. The risk assessments and care plans were not always reviewed and those reviewed did not always provide staff with up-to-date information about people's needs. There was no evidence of learning, reflective practice and service improvement. Information to support performance monitoring and making decisions was inaccurate, unreliable and out-of-date or not gathered. Information about people, their life history, hobbies and significant events in their lives was not always explored and incorporated into care plans, risk assessments and hospital passports.
- The service failed to update their statement of purpose after the new provider took over in August 2018.

This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The service failed to notify us about the unexplained bruising reported by one person's relative.

This was a breach of Regulation 18 CQC (Registration) Regulations 2009.

● The service worked in partnership with local authority. This resulted in some improvements such as servicing ceiling hoists, reviewing policies and creating a complaints log. However, other actions requested by the local authorities such as updating risk assessments or reviewing PEEPs did not result in improvement although, they were signed by the provider as completed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
● Care plans stated that monthly updates would be provided to families, but people's relatives told us they had not received updates since November 2018 and were worried about the service. One person's relative told us, "It would be nice to get a monthly/weekly report of what [person] is up to, what meals he is having and so on, because he doesn't talk. We have asked them about this".
●People relatives told us they were able to participate in the relatives' meeting organised by the service. One person's relative told us, "We now have a parent's meeting once a month, we never met them before so we meet the other parents now".
● Staff told us they felt well supported and were able to contribute to the service by participating in team meetings. A member of staff told us, "It is important to have team meetings. We discuss our support, rota and staffing, and need of our service users".

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 18 Registration Regulations 2009 Notifications of other incidents We were not always notified about incidents occurring at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users were not always provided with the consent of relevant person.

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 The care and treatment of service users did not always meet their needs, ane not always reflected their preferences.

The enforcement action we took:

We asked provider to submit an improvement plan of what action needs to be completed to be compliant with Regulation 9.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care and treatment was not always provided in a safe way. Risks to health and safety of service users were not always recognised or appropriately managed. Medicines were not always managed safely.

The enforcement action we took:

We asked provider to submit an improvement plan of what action needs to be completed to be compliant with Regulation 12.

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 Systems and processes not always operated effectively to prevent abuse of service users. Systems and processes not always operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse.

The enforcement action we took:

We asked provider to submit an improvement plan of what action needs to be completed to be compliant with Regulation 13.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to make sure they assessed, monitored and improved their service to ensure people received safe care.

The enforcement action we took:

We asked provider to submit an improvement plan of what action needs to be completed to be compliant with Regulation 17.