Caritas Care Limited

Caritas Care Limited - 218 Tulketh Road

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on the 5, 9, 10 and 11 March 2016. The provider was given notice of the inspection to ensure someone was available in the office to support us.

The service was last inspected In July 2013 where it was found complaint with the regulations inspected. This is the first inspection under the new methodology, where the service has been provided with a rating under the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

This report is for the inspection of the supported living service. The service supports 35 people living with learning disabilities in the community. Some people live in their own homes and some live with their families. The service supports people living in Lancashire.

The provider operates a number of other services including services accessible to people supported by the supported living team. These include day centres, self- advocacy services, befriending services and social and educational projects.

The provider has a manager who is registered with the commission. 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.

We found risk assessments were completed as required on both the properties where people lived and for specific risks to people using the service. We saw the provider had a good set of policies and procedures to protect people and staff as the service was delivered.

However we found the safeguarding policy needed updating to include key contact information and staff needed further information on who to inform in the event of a suspected act of abuse including notification to the Care Quality Commission. We found the service in breach of the regulation associated with ensuring that people were safeguarded against potential acts of abuse.

The service had recently reviewed a number of policies including those associated with medicines and infection control. We discussed these with the provider and registered manager who acknowledged work was ongoing to ensure their full implementation.

Recruitment was undertaken equitably and safely with potential staff. People using the service were involved in the selection of future staff where appropriate. Suitable checks were undertaken to ensure people were suitable for the role they were applying for.

We were told by staff that the induction to the role was good and ongoing training was provided. A new suite of training had recently been commissioned which staff were looking forward to attending. Staff

undertaking clinical tasks were to complete competency tests shortly after the inspection to ensure they were competent in supporting those people with more complex needs.

We found some concerns around how the service acquired consent from people. Consents had been acquired before people had been assessed to determine if they could safely give their consent. We discussed this at length with the provider and registered manager who were to implement the guidelines with the Mental Capacity Act 2005 as a matter of urgency. We found the provider in breach of this regulation but were given assurances work had begun to address these concerns.

We spoke with four people who used the service in their homes and saw four others whilst participating in planned activities. We saw relationships between staff and people using the service were well developed. Staff were knowledgeable about people's likes and dislikes and understood triggers that could result in changes in behaviour or health care needs. We saw staff reacting appropriately in all the situations we observed and people being supported were very happy.

People we spoke with spoke about their support workers in a high regard and staff spoke about the people they supported with admired warmth. People's dignity was upheld at all times and the service and its entire staff did everything within their power to make people's lives easier. This included liaison with professional teams to ensure family members received appropriate support and equipment to meet the needs of people using the service.

When people were first referred to the provider the service completed a comprehensive pre assessment including all available information. The service liaised with all involved professionals and relevant family members. We saw this information was then used to inform the care plans for staff to have the key information they needed to support people.

We saw the service worked with people's likes and dislikes and ensured people had access to services and activities to best meet their needs. We noted the provider had a number of key services to better support the people using the supported living service and access to these was available if appropriate. We also saw the provider had set up additional services based on the needs of people using the service. The provider had determined that people using the supported living service held full lives during the week when services were predominantly open. Good friendships were formed at this time and people requested a safe environment to develop and maintain these friendships without the structure of the groups or day centres. Caritas care consequently accessed and secured funding for the Saturday maintaining and developing friendships group that many of the people using the supporting living service attend on a Saturday.

Good information was given to people when they first started using the service including information about the service and available activities and projects. Key themes were explored, including, dignity and safety and information was provided on what people should do if they were not happy with something. This included information on how to complain.

The provider had recently set up a comprehensive system of business monitoring and improvement. The results of monitoring, actions from meetings and performance against targets were all collated and delivered to the management team by way of a Balanced Score Card (BSC). The BSC was shared with management and further actions were agreed for improvement and development.

The new staff newsletter shared the results of the BSC with the wider staff team and enabled staff to understand the quality assurance methods used by the provider. Staff we spoke with were beginning to understand the process and knew how the results of pieces of work they completed, were included within

the monitoring.

Staff we spoke with were happy in their role and enjoyed working with the people they supported.
We were told they were well supported by both their peers and management. Feedback was acquired from the staff team by way of a staff survey, newly implemented feedback boxes in all the provider offices and through supervision and appraisals.

The Provider and service were proactive in addressing any concerns raised during feedback after the inspection and we received an action plan with three days.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

Risk assessments were completed on properties people lived in and on specific risks to people using the service.

The service had good procedures in place to reduce the risk of major incidents and people's individual circumstances had been considered.

The provider needed to further consider the safeguarding policy and ensure relevant professionals were informed when risks presented themselves.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff were suitably trained to deliver the service and received appropriate support

The provider had not implemented the principles of the Mental Capacity Act 2005.

The service supported people effectively with their nutrition and hydration

Is the service caring?

Good

The service was very caring.

People we spoke with told us and we saw all staff were respectful and treated people with dignity.

Relevant people were involved with initial assessments and the service provided was based on people's likes and dislikes and delivered in accordance to their support needs.

The service worked with people and their families to ensure the best possible service could be provided.

The provider sourced new projects to meet gaps and needs in

people's social development.

Is the service responsive?

Good

The service was responsive.

People's needs were met by the service.

People, their families and support network were given opportunities to feedback to the provider on the service they received.

People were given information on how to make a complaint

Is the service well-led?

Good

The service was well led

The service had a developing system of audit and improvement.

Staff had the support of a comprehensive set of policies and procedures and a staff handbook.

Staff were actively involved with the development of future projects and how the service developed.

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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 was 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 took place on 5, 9, 10 and 11 March 2016. The day was announced to ensure someone would be available in the office to support the inspection. The inspection team consisted of one adult social care inspector.

Before our inspection, we reviewed the information we held about the service including the details of the previous inspection.

During the inspection we spoke with the registered manager, the day services manager, the head of community services, the Chief Executive Officer (CEO), team leaders and support workers. We also spoke with four people who used the service whilst we visited them in their own home.

We reviewed the Care file information held at the office of six people who used the service and reviewed the information held in the four people's homes we visited.

We looked at the available information in the public domain including the provider's website. We were given publicity material and a copy of the provider's business plan.

We reviewed available information to show how services were managed and how the staff were supported and trained to complete their role. We saw how people who used the service were asked and gave their feedback and saw available information for people who may wish to complain.

We visited a day centre where people using the supported living service with complex needs were supported each day. We also saw an education project that was attended by people using the supported living service. We were told of other initiatives including a weekly disco and self-advocacy service that people also used and saw how the initiatives supported people's health and wellbeing.

We reviewed the personnel files for five members of staff, monitoring records and management information used to better support people using the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe in their homes and with the staff supporting them. One person told us, "[staff member] is great and is my friend and takes care of me." We saw positive relationships between staff and people using the service in all the homes we visited.

We reviewed the provider's safeguarding policy and found it identified the types of abuse and advised readers on the appropriate action to take. However the phone number for the Local Authority safeguarding team had changed some time ago and the policy needed updating to reflect this. We also noted the policy did not inform staff that the Care Quality Commission also needed to be informed when abuse is suspected and we found management had not routinely completed notifications of abuse as a consequence. We did see posters were located in the staff offices and in the homes we visited and staff we spoke with were confident to raise concerns with the team leaders if they felt it was required.

The safeguarding procedures did not specifically identify the safeguards around restrictive practice and we saw within people's files this was used to keep people safe. This included the use of lap belts on wheelchairs and bedrails and on one occasion a door was locked to the kitchen to enable staff to cook safely. We could see from the care plans these were used in people's best interest but the correct procedures had not been followed to ensure they were lawful.

The service worked within some difficult circumstances, some of which could be better coordinated with the support of the Mental Capacity Act and the use of the local safeguarding team. We asked the registered manager to raise a safeguarding with the Local Authority around a specific concern and were assured they had done so.

When services do not appropriately raise concerns of potential abuse with the appropriate parties including the Local Authority safeguarding team and the Care Quality Commission and do not follow the required legal procedures before restrictive practice is used this is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service undertook risk assessments on the properties in which they supported people and had good assessments to support lone working. Staff we spoke with told us they felt supported within their work.

We reviewed the procedures the service implemented for health and safety aspects of the properties people lived in. We saw one property had a very worn stair carpet that had become loose and was a potential trip hazard. Staff at the property told us the issue had been raised with the health and safety committee and whilst we could not confirm this during the inspection we were contacted shortly after to confirm the carpet was to be replaced. This showed us the provider was proactive at reducing the risks to people living in supported accommodation.

We saw fire equipment was in place at properties and staff had recently completed evacuation drills. People using the service had assessments completed that identified the support they needed for safe evacuation.

We reviewed the available information on accidents and incidents and saw the staff ensured this information was recorded and escalated for investigation as required. The service collated a large number of reports each month and a recently implemented electronic system was to be used to collate this information monthly. This would enable the service to better identify themes and trends in records, to ensure actions could be taken where possible to mitigate any risks

Staff were recruited dependent on the needs of the service. People using the service or family members were involved in the recruitment procedure where appropriate. This gave both potential staff and the people who they would be supporting an opportunity to meet and ensure the development of positive relationships. People who used the service predominantly had the same support staff to allow people to be confident with the team supporting them.

We reviewed the staff records for five of the staff working on the service. We found staff had been recruited equitably. We saw interview records and appropriate references had been received before staff started work and checks had been undertaken with the DBS (Disclosure and Barring Service). All personnel files had a photographic identification for the staff member

We saw one reference from a previous employer that identified a potential risk for new employers. The provider had not completed a risk assessment to ensure this person was both suitable for the role and the provider did not need to make any reasonable adjustments to reduce the risk of recruiting this person. The provider assured us this had been assessed and would be recorded as required going forward.

In the three homes we visited we looked at the procedures each home had for managing the person's medicines. We saw each home had a system developed around the needs of the person. We saw MARs (Medication Administration Records) were completed and PRN medicines, had agreed protocols, for how they were used. PRN medicines are medicines people require only at specific times, for example when in pain.

However, one person told us they would like more support with their medicines, as they often forgot to take them. We were told staff did not take steps to identify presenting side effects of this person not taking their medication. We discussed this with the registered manager who assured us they would undertake a review of this person's medication needs.

We looked at five medicines care plans and found they were not inclusive of all the identified risks. This included a lack of assessments to ensure people were safe to handle and administer their own medicines.

Procedures in homes were diverse and could lead to difficulty when auditing as procedures were not clearly defined. This was specifically at point of review where information was inconsistent. Some reviews included the detail of medicines and any changes and others didn't. This included short term medicines such as antibiotics. We discussed this with the registered manager who assured us procedures would be defined whilst remaining person centred.

The provider had procedures for infection control which had recently been reviewed. We were told they were aspirational at the time of the inspection but the provider was working towards their full implementation. The provider was required to negotiate with people and their families to ensure people and staff were protected by infection control procedures, whilst ensuring the person's dignity was maintained and their home environment did not become too clinical.

We recommend the provider reviews medication procedures and defines a consistent approach to audit to

ensure procedures are followed.

Requires Improvement

Is the service effective?

Our findings

People we spoke with who used the service, told us, they were happy and had things to do that they enjoyed. One person we spoke with told us, "I enjoy going to the disco and see all my friends there."

Staff we spoke with told us, the induction they received to the service they were to work in, was very good. It included time in the service shadowing more experienced staff and staff had the opportunity to get to know the service users before they began supporting them.

We reviewed the available training records and saw that a recent schedule of training had been launched. Staff told us the training was very good. Most staff had a nationally recognised specific care qualification. However, some staff responsible for clinical tasks including; supporting people using a tracheostomy (A tube used to support breathing) and percutaneous endoscopic gastrostomy (A tube used to support nutritional intake), had not had their competency in these tasks signed off by a clinician for up to four years. We raised this with the nurse lead for the service who assured us this would be undertaken as a matter of urgency.

Staff at all levels were supported by team meetings. At the meetings the needs of the service and those using it were discussed and actions were agreed or escalated as required. Management were on call 24 hours a day to support both staff and the family of people using the service. Front line management covered the rota supporting staff as required.

Staff had a six month probationary period to the role and we saw within the personnel files how this period was monitored and signed off. We also saw where staff had not been successful in completing the probationary period. This showed us the provider completed appropriate assessments of performance during this period.

The service received referrals predominantly from social services but also received self-referrals which were then coordinated with the relevant social work team. We saw pre-assessment information which took account of peoples' needs and this information was signed in agreement by relevant professionals and the service. However we did not see any evidence to tell us why the individual themselves did not consent to the information. We did also see consent given by individuals themselves, for certain aspects of their care, when it was clear the person did not completely understand what they were consenting too.

Where people lack the capacity to give consent to their own care and treatment the Mental Capacity Act (MCA) 2005 identifies clear guidelines as to how these people should be lawfully supported in their best interest. The service had not taken account of the MCA when gaining consent from people. We found one person had signed two consent forms, for how their medication should be managed and one conflicted with the other. The consents were written in a way that they were not easily understood by the person signing them. We were assured information was explained to the person before they gave their consent but it was clear if the person had completely understood they would not have given their consent, as it was not how their medicines were managed.

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.

We discussed with the provider how consent should be considered under the MCA 2005. We also discussed the authorities of both the Power of Attorney and Next of Kin and how these should be utilised when making best interest decisions. The provider had not implemented the MCA when acquiring consents from people using the service or their representatives this is breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) 2014. The head of community services assured us they would implement the principles of the MCA 2005 where this was required as soon as it was understood by the team of the supported living service.

The service supported people with their diet and nutrition and we saw examples of healthy eating plans and weekly menus. We were told by people using the service that they were supported with their shopping and preparation of their meals if appropriate. We also saw examples of the service supporting people with healthy eating and heard one person repeat the expectation from themselves to remain healthy including not eating too much chocolate.

We saw good examples of the service working with the learning disability network, social workers and the housing associations to directly support people using the service. This included negotiating and mediating difficult housing and support choices for people in transition from children to adult services. We found the service worked with the needs of the person they were supporting at the heart of what they did and from evidence we reviewed confirmed the most favourable outcome was secured.

We saw how the provider had representation on key stakeholder forums to shape best practice and develop joint ways of working to influence commissioning. We also saw evidence of how the provider worked across its own different services to share expertise and access to services to support the needs of people they were supporting. This included giving advice and support to the provider's adoption agency to better support one young person with complex needs with access respite care.

The provider worked with all health care professional involved with people using the service and through the development of comprehensive health action plans were able to ensure health care professionals met the needs of people they were supporting.

Good

Is the service caring?

Our findings

We did not ask people using the service directly about the relationships they had with the staff supporting them as it was clear from the homes we visited the relationships were supportive and trusting. Staff and people being supported showed in equal amounts, pride in the relationships they had with each other. Staff were caring and obviously knew the people they were supporting very well. One person told us about the items, they and their house mate had made in the various different classes they attended. They also showed us an item that had recently been won at a social event staff had supported them too.

People using the service had full lives with activities planned every day including educational, social, and spiritual and person centred activities. Plans were developed around people's likes and dislikes and one person we spoke with was planning their annual holiday to Tenerife. People we saw who used the service were well presented and had clearly defined routines to their day which helped people feel secure and safe in their daily lives.

We saw good examples of how the staff at the service went that extra mile to support people with their specific needs. For example one person needed to know which staff were supporting them and when, but were unable to read. The staff developed a colour coded rota where a specific member of staff was a specific colour identified by the person being supported. This enabled the person to ascertain who was coming to support them and when. This gave the person added confidence and eased their anxiety levels.

We were told how one person had not been able to safely access the community because of the lack of an adapted and safe vehicle. We saw how the service supported people with applications to secure specially adapted vehicles to enable access to the community. This had a positive impact on the wellbeing and welfare of this person as keeping socially active reduced risks associated with their learning disability. We saw the venue for the disco organised by the provider for people living with a learning disability in the community and two people who used the service spoke with us about how much they enjoyed it. We also saw two people who were going with staff for the evening to see strictly come dancing at a local theatre.

The service provided key information in an easy read format for people using the service to better understand the meaning of the text. Easy read is a form of language using pictures alongside simple text. Key documents such as health action plans were developed in this format. We also saw wash your hand signs and fire evacuation instructions in easy read around the provider offices.

At the time of the inspection one person who used the service had been admitted to hospital and we saw the registered manager kept in regular contact with the family of the person. We saw this contact offered support to both the person in receipt of the service and their extended family. The registered manager offered to take items into the hospital that the family requested.

Staff told us of occasions where management had supported relatives in difficult times and helped them access services when they were needed including specific end of life care and after death services.

We were told of difficult occasions where the wishes of the person being supported differed from the wishes of family members. The service mediated outcomes to meet the needs and wishes of the person using the service where ever this was practically and safely possible. There were also occasions where family members had not been able to secure the most appropriate equipment for their relative who needed specific specialist support. We were told how the service had liaised with the appropriate teams and secured better equipment enabling the person in receipt of support to sleep better and safer.

We saw people were treated with dignity and respect at all times and conversations with people were caring and friendly whilst respecting people's boundaries.

We were told of occasions where the service had changed hours of provision to work around activities and social occasions including staff working later into the evening to support people to events in the community including the pride festival in Manchester.

The provider told us where information was required in a language other than English it would be made available. The service used a number of communication methods including sign, Makaton and easy read. We saw access to services used by people using the supported living service were safe and fit for purpose.

Good

Is the service responsive?

Our findings

We spoke with three people about how the service supported them and were told different accounts of how this was done. One person told us, "They help me see [friend] at the weekend. We had been told by the registered manager that a number of people using the service had developed friendships with others at the activities and events they attended but it was more difficult for people just to meet up. The provider had therefore set up a developing and maintaining friendships group on a Saturday morning in one of the community buildings. This allowed people to meet up with others at times other than when structured activities were taking place.

The service was revising the business brand to account for the new structure and had printed a number of improved care plan documents ready for use by the service. However at the time of the inspection the six care plans we looked at were difficult to follow. The provider took immediate action and implemented an audit to ensure all plans followed the same content layout. This would have made it much easier to find the information in the files.

In the information we reviewed we saw a comprehensive pre-assessment process completed with people, their families and social workers where applicable. This information was used to develop person centred plans which were reviewed mostly monthly or as required. In the files we looked at we saw that information at point of review did not always lead to an update in the care plan. This included formalising changes in support offered to one person who was currently using a short breaks service. The registered manager assured us this would be updated.

The provider operated a number of services to support people living with learning disabilities. People using the supported living service had good access to other services as a result. This included day services where people with complex needs met to take part in group activities or go out on day trips. We met two people using this service (FX) on the day of the inspection who were also supported by the supported living service. There were also educational programmes at the VIP project where again we saw two people who were supported by the supported living service undertaking a journey through life paper based exercise. People we saw using these services were engaging with what was going on and enjoying them.

We were also told of two other projects operated by the provider that people using the supported living service engaged with. This was a self-advocacy service which operated on a national scale supporting and influencing change for people living with learning disabilities and a speak out project delivering arts and interactive workshops.

Over the course of the inspection we heard of different examples of support being delivered that was responsive to the needs of the people using the service and their families. One person was in transition from children's to adult services and was beginning college. The family were very anxious about the transition and were understandably concerned of the impact on their child. The supported living service phoned the parent every two hours to update them on the progress of the day and to reassure them their child was coping well with the transition. This additional support to the family gave them the added confidence in

their child's ability to cope with the transition and put them at ease they were safe during the process.

The service had a clinical team including a lead nurse for the supporting living service, the nurse had an overview of the people's needs that were living with complex needs and provided clinical oversight for the staff supporting these people.

The service worked with people living with a learning disability and as such faced complex and changing agendas. We spoke with one person who wanted to be moved to another home and had moved a number of times already. The service was taking steps to try and secure a more permanent residence. However this was not clearly recorded within the person's care file. We spoke with the registered manager about this who assured us the detail of the needs and wishes for the move and assessments undertaken would be included within the person's care plan.

We saw comprehensive records of people's care and support needs in their homes and staff updated daily records identifying how the plans were met. Good records were kept of people's diet and their personal care needs. It was clear everyone we met was happy, content and well cared for by the service.

People using the service were given information when they started using the service. This included an introduction pack which included a complaints procedure. We saw complaints posters were displayed on notice boards within the provider office.

We reviewed the available complaints and saw the last one recorded was December 2015. A log was kept of the complaints in a note book and a record was made of the actions taken. This information was to be added to the electronic system and the complaints policy was to be fully implemented at this point. The electronic system would be able to identify themes and trends and as with accidents and incidents monthly or quarterly monitoring could be undertaken to identify any action required to mitigate any risks.

Good

Is the service well-led?

Our findings

Since the last inspection in 2013, the provider had commissioned a further service to become part of the supported living service. This now meant the service was providing support for 35 people living with learning disabilities in the community. We saw the provider was bringing the two services in line and developing procedures to ensure the service ran under the registered manager effectively.

The current manager had been in post for some time and worked for the provider as services changed and developed to become what it is today. The provider had diverse services from nursery provision to offender services and had a diverse skill mix in the management team as a consequence. The provider had recently developed a provider forum where all the managers across services met to share skills and expertise.

A recent manager away day had also allowed a shared understanding of the challenges and achievements of the provider and a developed action plan was owned by the managers across the provider services. Management across the provider were involved in local stakeholder events and were engaged with the changing commissioning landscape and worked to influence agendas to meet the needs of the people they supported.

We saw how staff at all levels were involved with the development of new services and innovation The team meeting minutes showed us the provider requested input from all staff on how to improve provision and included any approved innovations into the budget setting round for the forthcoming year. This included the recently launched Saturday developing and maintaining friendships project. The staff we spoke with told us they felt involved with developing services and felt that their input was valued.

Staff had recently completed a survey and the provider wanted to target a higher proportion of respondents. Feedback from recipients included concerns over the anonymity of responses using the survey tool the provider had selected. As a consequence the provider had set up feedback boxes in all provider offices and requested staff to submit any feedback. They had also arranged for a paper survey to be sent out shortly. However we found that nearly 100 staff had responded to the survey and some responses required attention including up to 20% of those respondents not always being happy at work. We acknowledged the supported living service could be a difficult service to work in but the provider had responded well to a staff survey completed in 2014. We discussed this with the provider who acknowledged more could be done to respond to the initial responses to the staff survey.

We saw all service certificates were in place for the provider offices including fire equipment and gas and electrical installations.

Quality improvement processes were currently being embedded from provider level. With the development of the electronic monitoring system the provider had developed a business score card which included key improvement performance indicators.

This was still a work in progress and whilst the available data was being utilised, work was ongoing to

ensure actions could be identified to continually reduce risks in service provision. This included the identification of themes and trends in both accident and incident records and complaints received. During the inspection the provider data analyst showed us the different ways in which the data could be manipulated to ensure these were collated on a monthly basis. The provider assured us that current monitoring of the records ensured these were collated but agreed more formal records of any identified themes could be kept and would be implemented as soon as possible.

The senior leadership team meeting minutes identified the constraints of the development and use of the business score card and it was clear a number of new initiatives were being developed to drive improvement including the manager's forum and a monthly newsletter to all staff. This gave us assurances the provider was working towards embedding systems and processes for collecting and collating data which in turn would allow for better interpretation and action planning to drive improvement.

The provider had a good set of policies and procedures which had recently been reviewed. Work was underway to embed the new procedures in practice including infection control, safeguarding and the complaints procedures.

We read a lot of positive compliments from both professionals working with the service and family members of people the service supported.

The provider prided themselves on providing and supporting people that may have not been successful in accessing support previously. The registered manager gave us appropriate assurances the service would only accept those people the service could safely and effectively manage and support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always acquired when it was required including for restrictive practice. Where consent was acquired it was not always acquired from an appropriate person who was able to give their informed consent.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not established systems to manage potential safeguarding concerns including the proper assessment and lawful use of restrictive practice.