Mr & Mrs D G Payne

McGillicuddy House

Inspection report

18 Vicarage Road
Strood
Rochester
18 Vicarage Road
Strood
Kent
ME2 4DG
Tel: 01634 711781

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Ratings

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

Overall summary

The inspection was carried out on the 10 and 11 November 2015 and was unannounced.

McGillicuddy House offers accommodation, care and support for up to 10 people with learning disabilities for those that are independent to those needing more support. The accommodation was provided over three floors in a semi-detached house with a communal living room and kitchen diner, bedrooms and communal bathrooms. There is a communal outdoor area at the rear of the property with a garden and summer-house. There were eight people living in the home when we inspected.

There was a registered manager employed at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like

Summary of findings

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 home is run.

People at the home said they felt safe and relatives told us that they knew their relatives were safe. There were safeguarding policies and procedures in place but these were not robust, in line with current legislation or in line with the Local Authority's policy. Whilst staff told us they knew what to do if they needed to whistle blow, there was not a whistleblowing policy available at the time of inspection.

Recruitment practices of employees were not robust. There were concerns over DBS checks not being updated and there were unexplained gaps in employment history.

The registered manager told us that they did not have methods in place to determine the amount of staff needed to care for people living in the home. There were not enough staff deployed at night. We have made a recommendation about this.

People had been involved in planning for their care needs. Care plans provided information and guidance for staff on how to support people to meet their needs. Risk assessments were not always person centred or updated when there had been a change in need for that specific person and at times risks were not identified.

We saw that staff had received training specific to people's health needs, not all training, including trainings that the provider considered mandatory was up to date. We have made a recommendation about this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager and staff could not demonstrate a clear understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We have made a recommendation about this.

There were policies and a procedure in place for the safe administration of medicines. People had access to GPs and other health care professionals. Prompt referrals were made for access to specialist health care professionals.

People had free access to food and drink and snacks during the day. People were involved in shopping.

Staff knew people that lived in the home well and were engaged in meaningful and fun conversations with people. Staff encouraged people to be as independent as possible.

There were regular minuted 'housemates' meetings where people were able to talk about things that were important to them and about the things they wanted to do. We saw evidence of people going to regular activities.

People were aware of the complaints procedure and they knew who to talk to if they were worried or concerned about anything. Relatives said that they knew who to complain to if they had any concerns and provided positive feedback on the home as a whole. We have made a recommendation about this.

The registered manager had sought the views of people living at the home as well as relatives. The results of these surveys were positive.

The quality assurance and monitoring systems were not robust enough to ensure the provider could consistently identify and act on shortfalls in the service in a timely way.

The registered manager and registered provider were not aware of their responsibilities in respect of reporting to CQC and were not up to date with current legislation.

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

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.

There were safeguarding adult's procedures in place but they were not in line with current legislation or the local authority's policy.

Individual risks of harm to people had not always been identified. There was no suitable guidance in place for staff.

The provider did not robustly follow its own recruitment policies and procedures to prevent people from being at the risk of harm from unsuitable staff.

There was not enough staff deployed to adequately meet people's need at night.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had completed an induction when they started work and received training relevant to the needs of people living in the home. However, not all training was up to date.

Staff did not have a clear understanding of the Mental Capacity Act or Deprivation of Liberty Safeguards and how this should be applied to support people using the home.

People's health needs were being met and medical intervention was being sought when needed.

People had access to food, drinks and snacks throughout the day.

Is the service caring?

Good

The service was caring.

Staff were caring and spoke with people using the service in a respectful and dignified manner. People's privacy and dignity was respected.

People's confidential information was securely kept.

People were consulted about how they wanted their care delivered.

Relatives were able to visit their family members at any reasonable time.

Is the service responsive?

Requires improvement

The service was responsive.

Staff encouraged people to be as independent as possible.

There were activities for people to partake in if they wished to.

Summary of findings

There was a complaints procedure in place and people and relatives knew how to use it if they needed to.

There was positive feedback from health care professionals about the care provided for people living in the home.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The quality assurance and monitoring systems in place were not robust enough to pick up issues that needed attention or improvement.

There were no daily recorded notes of people living in the home.

The registered manager and registered provider were not aware of their role and responsibilities in relation to notifying CQC of any incidents or serious injury to people.

Staff, people and relatives were positive about the Registered Manager and senior management at the home and there appeared to be an open and caring culture in the home.

McGillicuddy House

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 November 2015 and was unannounced. The inspection team consisted of two inspectors. Before the inspection, we reviewed previous inspection reports and notifications before the inspection. A notification is information about important events which the home is required to send us by law. We looked at safeguarding and whistleblowing information we had received.

We also spoke with three staff including a support worker, the deputy manager and the registered manager. We spoke to four people who lived in the home and one relative. We contacted health and social care professionals to obtain feedback about their experience of the home.

We observed care and support being provided. We looked at records held by the provider and care records held in the home. These included four people's care records, risk assessments, staff rotas, three staff recruitment records, meeting minutes, policies and procedures, satisfaction surveys and other management records.

We last inspected the home on the 01 May 2014 and there were no concerns

Inadequate

Is the service safe?

Our findings

People told us that they felt safe and that they knew who to talk to if they were worried or concerned about anything. One relative told us that they "Knew their relative felt safe here".

All staff had received training in Safeguarding Vulnerable Adults although some of this had not been updated since 2010. Staff told us that they had received training on safeguarding procedures and were able to describe the types of concerns they would report. There was a safeguarding policy in place; however this was not in line with current legislation, making reference to old regulations. Although the policy made reference to the Kent and Medway Safeguarding Vulnerable Adults Protection Policy, dated January 2014, it did not follow the guidelines within this policy. The Care Act 2014 places Adult Safeguarding on statutory footing and providers must report and discuss any allegation of abuse with the Local Authority, police (if appropriate) or the Care Quality Commission. Staff were not aware of reporting to the local authority safeguarding team and raising concerns. The records showed that the staff had not appropriately notified the CQC of safeguarding incidents. The staff and registered manager did not understand the arrangements in place to protect people from harm.

We looked at the policies and procedures and found that there was not a whistleblowing policy in place in the home at the time of the inspection. The provider forwarded a copy of this policy to us the day after the inspection. However, when we spoke to staff, they told us that they were aware of a whistleblowing policy and were able to tell us what they would do if they needed to whistle blow. Staff said, "We would always report it and it is very important". One health care professional commented that when asked if they had any concerns about the home, they said, 'Only that there appear to be a high percentage of staff related to each other and whilst I have no concerns what so ever I am unsure how the Whistleblowing policy would work.'

The above examples evidence a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were risk assessments in place for people. However, we found that they were not always reviewed when there had been a change of need for people. For example where there had been an accident in the kitchen with one person the risk assessment had not been updated. Some of the risk assessments were not personalised and there were copies of the same risk assessments in different people's care plans. We saw the same risk assessment for people with epilepsy going swimming in two different care plans. Some risks had not been identified. Risks associated with particularly complex health issues had not been fully explored and expanded upon. One record we reviewed showed that a speech and language therapist had identified a possible issue for one person, indicating that this person might be at risk of possibly inhaling food and drink. There was no risk assessment in place for this. The risk to some people had not been properly assessed and registered manager had not done all that was reasonably practicable to mitigate such risks.

The above examples evidence a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had carried out assessments to identify and address any risks posed to people by the environment. This included fire risk assessments. Fire drills were carried out regularly and people told us they knew what to do in the event of a fire. The deputy manager told us that fire training was covered in the syllabus course for Health and Safety. The training records showed us that all staff had completed this course. There were up to date gas safety records, fixed wiring electrical testing and portable appliance testing were in date.

The provider had a recruitment policy in place; however this was not always followed. The registered manager told us that the staff team consisted mainly of family members. Interviews were carried out and references were gathered, however, records indicated that gaps in employment history were not fully explored. In one file there was only one reference from a family friend was on file. It was noted that with some members of staff, where they had taken time away from working in the home, the Disclosure and Barring Service (DBS) check had not always carried out again, relying on the old checks, when they came back to work for at the home. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This may place people using the service at risk of receiving care from unsuitable staff.

Inadequate

Is the service safe?

The provider's recruitment policy stated that 'ensure that employees are asked at every supervision session whether they have received a criminal conviction or warning or notice of referral to the DBS which hasn't been declared'. We checked supervision records and this was not being asked. The provider was not following its own policy in respect of keeping people safe and people may be at risk of receiving care from unsuitable staff.

Failure to establish gaps in employment history, gather suitable references and carry out robust checks on staff are a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager told us that they did not have any systems in place for assessing or monitoring staffing levels to ensure that there was enough staff working and to meet the identified needs of people. The registered manager worked on the basis of one member of staff for four people. However, this did not take into account the complexity of people's individual needs or additional support that they might need. When we looked at records we could see that extra staff were brought in to work in order to enable people to carry out activities during certain times of the day. Staff rotas evidenced that between 8pm and 8am there was only one member of staff on duty. Some people were having to go to their room whilst there was still two member of staff on duty, to support them, because they felt safer to do so even though they might not want to go to their room before 8pm. There were not enough staff deployed particularly at night to make sure that people's needs were met.

We recommend that the Provider looks at putting in place a system in order to determine staffing levels on a needs basis and to consider staffing levels at night.

We observed a medication round where two members of staff were administering medication and signing the Medication Administration Records (MAR). Following the inspection we were forwarded a copy of medication audits and we could see that these were being carried out in line with the provider's policy on medication administration.

Requires improvement

Is the service effective?

Our findings

People were not restricted in going in and out of the home and we saw them coming and going freely, either with or without staff accompanying them.

There were no records in people's care plans that appropriate assessments had been carried out to see if people had capacity to do or consent to certain things. For example, it was not recorded that people had the capacity to consent to care and treatment from staff at the home. The deputy manager told us that they "don't really do mental capacity assessments." . When we spoke to care staff about their understanding of the Mental Capacity Act and how it affects their role they told us that it was "making sure that people make safe decisions. That they could choose but people need to be safe". One of the principles of the Act is that as long as people have capacity to make a decision, they shouldn't be deemed as lacking capacity even if they make an unwise or unsafe decision. We witnessed people making decisions for themselves, but there was no evidence that this was factored into care plans. The registered manager and staff did not demonstrate that they had a clear understanding of the Mental Capacity Act and how this should be applied to support people living in the home.

This evidenced a breach of Regulation 11 (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

None of the people living in the home were subject to a Deprivation of Liberty Safeguards order. Records evidenced that staff had received training in Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). People were free to come and go, with or without staff. However, there were no checks in place to consider if people needed a DoLS or if their capacity changed whether this would need to be considered.

Staff told us that they had completed induction training when they first started working at the home. Records seen showed that they had also completed nationally accredited qualifications in health and social care (NVQs) as well as completing other on line training. From records that we looked at staff had completed training which included fire safety, medicines, manual handling, safeguarding adults, infection control and managing behaviour that challenged others. Training was not always consistent and up to date.

Some people that lived in the home have complex health needs such as epilepsy. Records showed that 100% of the staff had completed training specifically in epilepsy and administering emergency medication for this condition should it be needed. Records showed us that on a recent food hygiene inspection there had been a recommendation by the food safety office for food hygiene training to be updated. We saw that the home had booked on line training in food hygiene, for all staff. However, training considered mandatory by the provider in areas such as safeguarding and administration of medication and infection control were not up to date. For example the Registered manager last completed safeguarding training in January 2012 and the deputy manager in August 2011. This meant that staff did not always have the skills to support people effectively.

We recommend the provider reviews training for all staff and plans for gaps and training updates.

Staff told us that they regularly had supervision and an annual appraisal. We saw records of supervision which was carried out on a regular basis where good attendance and attitude were discussed.

Care plans were not kept in one folder, but were in several different places. People had been involved in some elements of drawing up their care plans. People had signed in agreement to some sections of the care plan but not in all the different folders. We could not see from the care plans that families had been involved in drawing up the care plans with their relative and the home. However, on relative told us that they were involved in the review of the care plan with the care manager from social services. "We have a meeting once a year with the care manager and that's when the care plan gets sorted." Relatives were invited to the annual reviews and attended should they wish to do so.

Where people who suffered from epilepsy, staff were provided with clear guidance on signs and symptoms to recognise. Details in care records included actions staff should take in the event someone suffered from an episode and where people had different types of epilepsy this was recorded, described and guidance given. A log of episodes was kept by staff to allow them to monitor the frequency and severity and this was used to take to appointments with epilepsy specialists to help inform treatment. The registered manager and staff responded quickly to people's changing health needs. For example, care records showed

Requires improvement

Is the service effective?

us that people's health needs were being met and medical intervention was being sought when needed. We were able to see that other professionals with specialisms in the areas needed to support people were involved on a regular basis. One health care professional told us that where there had been a change in one person's condition "they were on the phone a lot" to discuss and get best advice. This showed that staff were aware of that person's individual needs and knew how to access the right health care support. We received positive feedback from health care professionals that either visited the home, or were involved with people that lived at the home. One nurse specialising in epilepsy said "The person always comes to my appointment with the same carers. They are very tuned into their needs and notice any signs of change or deterioration. They always come very well prepared for the appointments".

We saw people were able to help themselves to tea and coffee and snacks throughout the day. One person was making his own breakfast when we arrived at the home. During the course of the inspection, we saw people being supported by staff making cakes and scones. People told us that they were involved in food shopping and that they were all involved in ordering the food shopping on line from the supermarket. People decided the food choices each day rather than there being a pre-set menu and then they could choose what they wanted for their main evening meal. One relative told us their relative was "Eating better than they had done for years" and "They know how to treat them". They went on to say that their relative didn't like to eat certain types of food that was healthy, but that since they had been at the home they now ate that food. "They encourage them to eat healthily". Weights of people had been recorded in care plans but only up into March 2015. Following the inspection we were informed that the weight records were kept in a separate file.

Good

Is the service caring?

Our findings

People were very positive about the staff and living at the home and told us "I'm very happy here", "I really like it" and "I have lots of friends". Another told us, "I really like my room." Another person told us the deputy manager "Is like my sister" and "It's much better than where I was before".

Throughout the course of our inspection we observed staff engaging in meaningful conversations with people. People were treated with kindness and understanding. People were comfortable with staff and staff knew people very well and what they liked and didn't like. One member of staff said, "We make sure that people are at the centre of everything we do" One health care professional told us 'Without exception the staff I met were kind and caring, McGillicuddy was very supportive and homely.' Relatives told us that "They have gone out of their way to accommodate" their relative and "They do care. Nothing is to too much." There was a service user guide which was in an easy read format for people in the home. This was in a pictorial format. It showed what to expect from the pre assessment before going into the home, where the home was, that they would have their own bedroom and what they could expect to do whilst living in the home.

Staff members were able to tell us about how they protected people's dignity and privacy, for example, when they were providing support with personal care, always telling people what they were going to do. Staff told us that they would never discuss people's confidential information with other people, including housemates. There was no manager's office where people or relatives could have private conversations however; relatives told us that "Confidential conversations can be held elsewhere, either in the summer house or bedroom". Therefore protecting people's privacy. People's confidential records and care plans were kept in locked filing cabinets only accessible by staff authorised to do so.

Support was individual for each person. People were able to make day to day choices about their care, such as the food they wanted to eat, activities they took part in or the clothes they wanted to wear. People were able to choose where they spent their time including in their rooms, in the communal areas such as the lounge or dining room and if and when they wanted to go out. For example, one person went out for a morning walk. Some people decided they wanted to go to the local market and when they returned, one person had bought their own lunch home. Other people were seen making their own breakfast's and hot drinks for themselves and staff.

We saw that people were positively encouraged to maintain relationships with family members. One relative told us "I can visit here any time I like". They also told us that sometimes their relative comes home to them, and they have had all the housemates' home with them.

People showed us their bedrooms, all of which were different and personalised to their own taste, with their own furniture and painted in colours of their choice. It was clear that people were very proud of their bedrooms. One person told us "I like my room".

Minutes of "housemates" meetings showed that they discussed issues around the home and the running of it and "housemates" survey's going back to 2014 had very positive feedback about the home.

Requires improvement

Is the service responsive?

Our findings

People were excited about a drama group that they were involved in and that they had set up with the deputy manager. They were putting on a show of "The Wizard of Oz" which they were all taking part in and rehearsing on a weekly basis. People told us about the parts they were playing and what preparation they were doing for the final performance.

People were regularly involved in activities. People and their relatives were going swimming at the local hydro pool. A trip to the gallery had been arranged for later in that week, and the previous evening some people had been to see a Christmas show. People told us that they regularly went to the cinema and bowling. People talked about what films they had seen and what they would like to see. They also spoke about a Halloween party they had just had at the home. People were excited to show us a photo album of the summer holiday people and staff had taken that summer. We saw copies of 'housemates' meetings, which were chaired in turn by each housemate. They discussed issues around the house as well what activities they would like to do and where they wanted to go on holiday. Every Monday evening some people would go to the local church to play bingo. People were involved in activities of their choice that kept them occupied and stimulated.

Assessments had been undertaken to identify peoples' needs before they moved into the home. Care plans included a person centred folder where details of peoples' like and dislikes had been recorded as well as goals they would like to achieve. However, some of these plans had not been fully completed and were not dated. Care plans were not regularly reviewed and updated. This meant that people may be at risk of harm from out of date guidance.

People and staff were actively involved in a multi-agency research project. The project manager who worked with the home said 'I have known residents and staff there for almost eight years' When asked what they thought the home did well they replied that 'I have always been impressed by the way that McGillicuddy encourages clients to be interested and active in their community. They show great respect to clients and the house is a real home'. One Care manager told us 'It appears to be run as a family home, rather than a residential home. My client's and families always look happy and engaged. One person I moved from another provider never engaged in their review and seemed listless, hence the move. Since living at McGillicuddy their eyes are alive, they engage well and their parents are included in all social activities.'

The home had a complaints procedure in place. The information included contact details for the Care Quality Commission (CQC) however; it did not include the contact details of the provider's head office, social services or the local government ombudsman. Records showed that they had not received any complaints. Relatives told us that if they needed to complain they knew who to speak to. One person told us "I would speak to any member of staff. I have no worries about speaking to staff, they are like family". Staff told what they would do in the event that either a person living in the home or a relative wanted to make a complaint. They knew about the complaints procedure and how to use it. The registered manager told us that there was not an easy read complaint procedure available.

We recommend the home reviews its complaints procedure and explores other formats to present this in relevant to the people living in the home.

We saw copies of 'housemates' surveys with lots of positive comments. One relative told us they had recently completed a relative's survey asking their opinion on the home. We also copies of thank you notes and cards from relatives all of which had positive messages of thanks to the staff and home for the care their relatives had received. A recent visit from Medway Council's social services commissioning department came back with a positive report on the home.

Requires improvement

Is the service well-led?

Our findings

Relatives told us that they thought the home was well led and that whenever they visited there was always a senior member of staff on duty. We received positive feedback from care managers and other health care professionals who all said that the home appeared to be well led.

We spoke to the registered manager about what systems and processes there were in place to audit and monitor the quality of the service as well as monitoring the risks relating to health and safety around the home. We were shown a check list that they used. This check list was not an auditing system and therefore it could not identify areas of concern or where improvements were needed.

For example, audits had failed to pick up that care plans had not been reviewed. The provider's statement of purpose specifies that 'The care plan is reviewed at any time at the request of the housemate, or at least every six months and updated to reflect changing needs'. Goals people would like to achieve had been set; however, these goals had not been reviewed and updated since February 2015. There was no evidence that goals had been achieved or new ones established which meant that some people might not be reaching their full potential. This was not being monitored.

There were no daily records of how people living in the home were cared for and what treatment they had received on a day to day basis. For example, of how people had been cared for, or what might have happened to them during the day, or what they had eaten. When we spoke to the registered manager about how they recorded what had happened to people during the day they told us that they noted what activities people had carried out, but that they did not make detailed notes.

The deputy manager had reviewed and updated the homes policies and procedures but they were not in line with current regulations or new legislation. The registered manager did not have a robust knowledge of The Health and Social Care Act (Regulated Activities) Regulations 2014 or current legislation and therefore was not aware that some of the policies and procedures were not fit for purpose. The quality assurance and monitoring systems were not robust enough to ensure the provider could consistently identify and act on shortfalls in the service.

The examples above demonstrate that the provider has failed to operate an effective quality assurance system and failed to maintain accurate records. This is a breach of Regulation 17 (1) (2) (a) (b) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager told us that their responsibilities were "To keep a happy ship, keep people safe, with a stimulating environment. To do paperwork, maintenance and involve the housemates. I'm a figure head". They went on to say that the deputy manager "does a fair amount". When we spoke to support staff they were aware of their roles and responsibilities. They knew the structure of the home and they knew who the registered manager and deputy manager were and who to report things to if they needed to.

We spoke to one member of staff who told us that the management encouraged an open and honest culture and that the management team were very approachable. "You can literally discuss anything here". We saw minutes of staff meetings where new policies and procedures were discussed with the staff team as well as the next housemates' holiday next year.

The provider's statement of purpose in part, sets out the aims, objectives and philosophy of the home. We were able to see through observation, talking to (people) 'housemates' and staff that on the whole these aims and objectives were being met and that the registered manager was actively encouraging the visions and values of the home. Staff were observed promoting dignity, respect, promotion of independence, risk taking and activities.

The management team at the home included a registered manager and a deputy manager. The provider visited the home on a regular basis to provide support to the registered manager and to carry out monitoring and audits of the home. These audits did not establish that some care plans had not been reviewed or signed and dated in all areas. They did not establish that some risk assessments were not up to date. The registered manager told us that they felt well supported by the provider and that they were available on the phone at any time. They also told us that they had a reasonably free reign in terms of the running of the home and that they could get things done, within a reasonable budget. If people wanted to do things then they were not restricted by funds.

Requires improvement

Is the service well-led?

The registered manager had regular supervision from the provider. Areas discussed in the latest supervision were up to date training and knowledge of regulations and legislation. The registered provider had not established that the registered manager was not up to date with training, and did not have a robust knowledge of the current regulations. The registered manager told us that they were aware of the changes in regulations that had come into force in April 2015 however; policies and procedures did not reflect the change in regulations.

The registered provider and registered manager did not have a good understanding of their role and responsibilities in relation to notifying CQC about important events such as injuries, Deprivation of Liberty Safeguards (DoLS) authorisations, safeguarding, and if they were absent from their role. Notifications had not always been sent in to tell us about incidents that required a notification. For example, the CQC had only received one statutory notification in the last five years; however, there were other incidents that should have been reported to CQC. There were records of safeguarding meetings that had taken place where the registered manager had not notified us of the safeguarding alert. There had been incidents recorded in the home that had occurred between people living there that had not been reported as a safeguarding incident to either the local authority or CQC.

This failure to notify CQC was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

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 provider did not take into account the need for consent or have a clear understand of the Mental Capacity Act 2005** **Regulation 11 (4)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **The provider did not always assess the risk to health and safety of people.** **Regulation 12 (1) (2) (a) (b)**

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 **How the regulation was not being met:** **People who use services were not always protected from abuse and improper treatment as systems and processes were not effective to prevent the above.** **Regulation 13 (1) (2) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The provider has failed to operate an effective quality assurance system and failed to maintain accurate records. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The provider had not notified CQC about important events such as, abuse and serious injuries. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider was not exploring gaps in employment history. Regulation 19 (2)