Connor Associates Limited

Holywell Home

Inspection report

17 West End Road
Morecambe
Lancashire
LA4 4DJ

Date of inspection visit:
08 April 2016

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28 July 2016

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

The inspection visit at Holywell Home was undertaken on the 08 April 2016 and was announced.

We informed the new manager 48 hours before our visit that we would be coming. This was because the home was small and we wanted to ensure people were available to talk with.

We had received several concerns about people's safety and the management of the home. We checked people were not at risk of receiving unsafe care.

Holywell care home provides accommodation, nursing or personal care for up to six adults with a learning disability. There were five people living at Holywell Home at the time of our inspection.

The home is situated at the West End of Morecambe, close to the promenade and within easy access to local amenities. There are two communal lounges, one on the lower ground floor and one on the first floor. There is also a combined kitchen and dining room on the lower ground floor. There is no lift therefore the home is not suitable for people who cannot manage stairs.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The provider had recently appointed a new manager who was applying to become the registered manager.

At the last inspection on 03 September 2014, we found the provider was meeting the requirements of the regulations that were inspected.

During this inspection, we found staffing levels were not sufficient to keep people safe from harm. Poor staffing levels had meant people who required care and support were at risk.

The provider had not managed risks to two people they supported. Risks had been identified but safeguards to keep them free from danger had failed.

People did not receive care that was responsive to their changing needs. The provider failed to ensure there were systems to manage people's individual behaviours and keep them safe.

The provider did not have accurate and complete records to instruct staff on how to provide help to people safely. Records identified what help people required but did not instruct staff how to support them.

Not all staff had regular supervision meetings with a member of the management team to review their role and responsibilities.

The management team had not fulfilled their regulated responsibilities. They had not notified CQC and the local authority of all events and occurrences as required.

The provider had oversight of the home but failed to act to maintain the quality of the care provided.

Staff had received abuse training. They understood their responsibilities to report any unsafe care or abusive practices related to the safeguarding of vulnerable adults. Staff we spoke with told us they were aware of the safeguarding procedure.

The provider had recruitment and selection procedures to minimise the risk of unsuitable employees working with vulnerable people. Checks had been completed before any staff started work at the home. This was confirmed from discussions with staff.

Staff responsible for helping people with their medicines were trained so they were competent and had the skills required. Medicines were safely and appropriately stored.

Staff received training related to their role and were knowledgeable about their responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs.

People and their representatives told us they were involved in their care and had discussed and consented to their care. We found staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Comments we received showed people we spoke with were satisfied with their care. The provider, new manager and staff were clear about their roles and responsibilities.

A complaints procedure was available and people we spoke with said they knew how to complain. Staff spoken with felt the management team were accessible, supportive and approachable and would listen and act on concerns raised.

The provider had sought feedback from staff and people who lived at the home. They had formally consulted with people and their relatives for input on how the home could continually improve.

The provider regularly completed a range of audits to maintain people's safety and welfare.

We found a number of 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had not safely managed risks to people they supported.

There were not enough staff available to meet people's needs and wishes safely.

Staff had been trained in safeguarding and were knowledgeable about abuse and the ways to recognise and report it.

Recruitment procedures the home had were safe.

Medicines were managed in a safe manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had regular meetings with a member of the management team to review their role and responsibilities.

The provider was aware of the Mental Capacity Act 2005 (MCA).

Staff had the appropriate training to meet people's needs.

People were protected against the risks of dehydration and malnutrition.

Is the service caring?

Good

The service was caring.

People who lived at the home told us they were treated with kindness and compassion.

Staff had developed positive, caring relationships and spoke about those they cared for in a warm, compassionate manner.

People were involved in making decisions about their care and the support they received.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not receive care that was responsive to their changing needs.

The provider did not have accurate and complete records to instruct staff on how to provide help to people safely.

People told us they knew how to make a complaint and felt confident they would be dealt with.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had oversight of the home but failed to act to maintain the quality of the care provided.

The new manager had clear lines of responsibility and accountability.

The management team had a visible presence throughout the home. People and staff felt the management team were supportive and approachable.

The provider had sought feedback from people who received support, relatives and staff.

Holywell Home

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.

The inspection team consisted of one adult social care inspector.

Prior to this inspection, we reviewed all information we held about the home, including data about safeguarding and statutory notifications. Statutory notifications are submitted to the Care Quality Commission and tell us about important events, which the provider is required to send us. We spoke with the local authority to gain their feedback about the care people received. This helped us to gain a balanced view of what people who accessed the home experienced. At the time of our inspection there were several safeguarding concerns being investigated by the local authority. These related to the safety and risk management of two people who lived at Holywell Home.

During this inspection, we spoke with a range of people about this home. They included two members of the management team, three staff, two people who lived at the home and two relatives. We spoke with two health and social care professionals. We checked documents in relation to four people who lived at Holywell Home and six staff files. We reviewed records about staff training and support, as well as those related to the management and safety of the home.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe, living at Holywell Home. People we spoke with told us they felt comfortable and safe when supported with their care. One person told us, "I am safe here, I like it here." A second person said, "I'm safe, the staff look after us." Observations made during the inspection showed they were comfortable in the company of staff supporting them. However, two people who lived at Holywell Home were not always safe. One person had left the premises five times without staff noticing, which placed them at risk. The last time had resulted in the person being taken to hospital for medical treatment.

We looked at what safeguards the provider had to manage the risks and keep one person safe. The provider had sought and received additional funding to increase staffing levels. They had allocated a staff member to deliver one-to-one support, Monday to Friday from 09:00 until 17:00, when the person was at the home, to keep them safe.

An incident occurred where the person left the home unnoticed and unsupervised. At the time of the incident the person should have received one to one support. We spoke with the new manager and deputy manager about the situation. We were told the member of staff identified to support the person, had failed to arrive at work the day before. They had not informed anyone they would not be attending work. On the following day, there was no staff member on shift to provide one to one support. The new manager told us the person chose to leave the home whilst a member of staff was dealing with a caller to the lower front door. Staff were unaware the ground floor door had been opened and failed to respond.

Staff were unable to say how long the person had been missing, before they realised they had gone. A member of the public found the person and sought medical aid. Within their current care plan staff recorded the individual was vulnerable and required one-to-one support to keep them safe'. This showed the provider was aware of the risks to the person but failed to have systems to keep them safe.

We asked the new manager why the front doors had not been locked to keep people safe. They told us they were awaiting legal authorisation to lock the doors. They wanted to be working within current MCA legislation. Prior to our inspection, a social worker from the local safeguarding team had visited the home. The management team had also met with a best interest's assessor. The best interest's assessor is a person who decides whether a deprivation of someone's liberty is occurring, or is likely to occur. They decide whether depriving someone of their liberty, is in the best interests of the person being assessed. The social worker and the best interest's assessor told us they advised the front doors be locked as an urgent measure. The provider disputed this stating the social worker told them they would seek advice on locking the door. However, the provider had failed to maintain people's immediate safety and keep them safe.

The new manager told us since the incident, they now had strategies to cover staff absence and ensure the person receives one to one support. They now had a group of three staff they could call to deliver support to the person. The three staff lived locally and were known to the person. We saw in the risk management plan staff had recorded if the person wanted to go out at night, staff must call the on-call and ask for help.

A second person who lived at Holywell Home had left the property unaccompanied on several occasions. Their health needs and limited capacity meant they were vulnerable and at risk of injury. A member of staff told us, "They are really, really poorly".

Members of the public had raised concerns regarding the person's safety when they had been out alone. They thought the person was lost and concerned they were dressed inappropriately. We spoke with a member of the management team about these concerns. They told us the roads the person crossed were not busy roads. They also stated that they had filmed the person crossing a road. The film showed the person looking left and right for traffic. The film was to help healthcare professionals to understand this person's condition. We saw in daily records a staff member had followed the person and given them a coat to wear and then returned to the home.

We did not see any support strategies to guide staff and minimise the risks involved. One staff member told us, "If [the person] goes out, I wait 15 minutes to 20 minutes then ring to get someone to look for them." This meant people were at risk from the time they left the home until someone was available to find them. We saw the person had a capacity assessment that indicated they had a significant learning disability. This showed the provider had identified serious risks but failed to implement strategies and safeguards to protect the person. We spoke with the new manager who told us there was now an on call system in place. Staff could telephone for extra support from the provider's domiciliary service. However, there were no written guidelines for this strategy and people would remain at risk until additional support arrived.

The provider did not manage risks effectively to keep people safe. This was a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staffing levels, observed care practices and spoke with people being supported with their care. We saw the deployment of staff throughout the day was structured. For example, the shift that began at 09:00 was for one-to-one support of one person. We were told the shift beginning at 10:00 was to support a second person with their personal care. This left a third member of staff supporting the remaining tenants. From 13:00, there was one member of staff supporting four people. From 17:00 until 09:00, there was one staff member on shift.

One person required one to one support from 09:00 to 17:00, however an incident involving the person took place when the support was not provided. A member of staff had not turned up for work and the one to one support was not provided.

This was a breach of Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure there was enough staff to respond to the changing needs and circumstances of people requiring support.

Staff demonstrated a good understanding of safeguarding people from abuse, how to raise an alert and to whom. There were procedures to enable staff to raise an alert. Care staff told us they would raise an alert if they had any concerns about inappropriate practice or conduct. Training records we reviewed showed staff had received related information to underpin their knowledge and understanding. However, staff told us they were unsure what to do and what action to take when people at risk left the home.

A recruitment and induction process was in place to ensure staff had the relevant skills to support people. We found the provider had followed safe practices in relation to the recruitment of new staff. We looked at six staff files and noted they contained relevant information. This included a Disclosure and Barring Home (DBS) check and appropriate references to minimise the risks to people from unsafe recruitment of potential

employees. The DBS check helped employers make safer recruitment decisions and prevent unsuitable staff from working with vulnerable people.

We looked at how medicines were dispensed and administered. Medicines were stored securely in a locked trolley, which, when not in use, was stored in a locked cupboard. Training records we looked at demonstrated staff had received training related to the administration of medicines. Each person had a medication administration recording form (MAR). The form contained information on prescribed tablets, the dose and times of administration. There was a section for staff to sign to indicate they had administered the medicines. This showed the provider had systems to protect people from the unsafe storage and administration of medicines.

Requires Improvement

Is the service effective?

Our findings

People did not always receive effective care, however people were supported by trained staff who had a good understanding of their needs. People told us they felt staff were experienced and well trained to support them. One person we spoke with said, "Staff are good at their jobs. They help me and calm me down when I get upset." A relative told us, "The staff know what they are doing."

We spoke with staff members and looked at individual training records. The staff members we spoke with said they received induction training on their appointment. They told us the training they received was provided at a good level and relevant to the work undertaken. Staff had received further training in safeguarding, moving and handling, good hygiene and the Mental Capacity Act 2005. All staff had received training in supporting people with complex needs. The aim of the training was to prevent, minimise and manage behaviour that challenged. Staff we spoke with felt the training was effective in giving them the correct skills to support people. This showed the provider had ensured staff received training appropriate to their role.

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 when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA 2005.

The provider demonstrated an understanding of the legislation as laid down by the MCA and the associated DoLS. The provider was aware of the changes in DoLS practices and had policies and procedures regarding the MCA and DoLS. Discussion with the provider confirmed they understood when and how to submit a DoLS application. We saw one person had a Dols in place and the provider had submitted an application to deprive a second person of their liberty. However where safeguards had been identified, in the persons best interest, the provider had not consistently followed these to keep people safe.

We asked staff about supervision meetings with their manager. One staff member told us, "I don't know when I last had one, but I can go to my manager if I am annoyed." A second person told us, "I've not had one for a while." We looked at records, which showed not all staff had received regular supervisions. Staff we spoke with felt if they had a problem they would be able to speak with a member of the management team. We spoke with the new manager who told us all staff would receive regular supervision in the future. Supervision was a one-to-one support meeting between staff and a senior staff member to review training needs, role and responsibilities.

We discussed the quality of meals with people who lived at the home. One person told us, "The food it's nice." They further commented, "The staff do the cooking, but I help." Another person stated, "The staff are good cooks." People who lived at the home had access to the kitchen. Some people made their own snacks and drinks. There was a four weekly menu in place. We were told the meals were not fixed and people could inform staff if they wanted something different. We were told breakfast was staggered and prepared as people got up. One person had chosen salad for lunch. They told us it was nice and they had enjoyed it. We were told people sometimes chose to go into town independently and have lunch in a café. One person told us they visited a relative for meals and sometimes the relative visited them for a meal. They told us they enjoyed having a meal with their relative, "Especially fish and chips." Staff provided support for one person with their meals whilst guidelines for another person stated 'I use a straw when I drink.' This showed information was available to staff to support people with their nutritional needs

Staff had documented involvement from healthcare agencies to manage health and behavioural needs. We saw people had Health Action Plans that guided people on how to remain healthy. We saw evidence of involvement from GP's, dentists, psychologists and opticians. For example, on the day of our inspection one person was supported to attend a medical appointment. On the same day, a health care professional had visited and delivered training to the staff team. This increased staff knowledge and skills and enabled them to share information with people effectively. Regarding managing people's health needs, a member of staff told us, "Making sure appointments are made; I think we are good at. We don't leave things, we take things seriously."

Good

Is the service caring?

Our findings

People we spoke with told us they were treated with kindness and staff were friendly and caring. We witnessed good interactions and communication between staff and people who lived at the home. Relationships between people and staff were open and friendly. Staff were knowledgeable about people's past histories and present likes and dislikes. One person told us, "The staff are nice." A staff member said, "People are loved, they are cared for here. They are happy"

When speaking with both people who lived at the home and staff, it was evident caring relationships had developed. Care staff spoke about people in a warm, compassionate manner. For example, one staff member told us they volunteered with one person and supported them to visit their relative. One person told us about the member of staff, "They help, they do a lot of things for me."

On the day of our inspection, people who lived at the home were visited by two police community support officers. We spoke with the officers who told us they visited regularly to build and maintain relationships with people at the home. They told us the relationship had been useful when people had required support to manage their complex behaviours. There was a rapport and familiarity between people at the home and the officers. One officer commented, they always get a hug if people from here see us in the street. The second officer told us, they had nothing but admiration for the staff; they go above and beyond for people. This showed people were supported to become part of their local community.

People we spoke with were very clear about Holywell Home being their home. It was apparent the provider had reinforced this with people. It was equally apparent people valued their connection with the provider. They quoted to us what the provider had told them regarding their rights and expectations of the home. For example, we were told, "This is my home, I can do what I want, I can go to bed when I want." They also commented, "[The provider] has told us, staff are not allowed to shout at us." This showed the provider had spent time with people and made them feel they would be listened to and they were valued.

During this inspection, we saw people had the option to lock their bedroom doors. This allowed privacy and time away from co-tenants and staff, when they wanted it. Staff were aware when people wanted time alone and respected their decision. We observed when staff knocked on bedroom doors; and they waited for people to respond. This showed staff respected people's right to privacy. When people showed us their bedrooms, we saw they had been personalised with pictures, ornaments and furnishings. Rooms were clean and tidy which demonstrated staff respected people's belongings.

We asked the provider about the use of advocates when supporting people. We were told people had advocates in the past and staff had worked alongside them to support the person. For example, one person had required hospital treatment. We saw records that indicated an advocate had been involved prior to the treatment taking place. This showed the provider had ensured people had support to express themselves.

We looked at care records and found people were encouraged to express their views. We saw evidence people had been involved in developing their care plans. The plans contained information about people's

current needs as well as their wishes and preferences. For example, we saw in one file, the person liked to be included in any decision making in the house. A second person's care plan informed staff the person was a private person and may not wish to speak with staff. This demonstrated people were encouraged to express their views about how their care and support was delivered.

We were told people who lived at Holywell Home had informal meetings together. We saw, having the home decorated and having a celebration party afterwards was discussed at the meeting. One person told us, "We need the meetings like the staff have. We talk about things, I like them." This showed the provider had systems to support people to express their views.

Requires Improvement

Is the service responsive?

Our findings

We looked at care plans of people to see if their needs had been assessed and consistently met. Two people at Holywell Home had not received personalised care that was responsive to their needs.

All the staff we spoke with had an understanding of people's planned care and how best to meet people's individual needs. One staff member told us, "We know people so well, we know how to respond." A relative told us, "The provider, they know and understand [my relative] really well." Care plans held information on the topics, 'Important to me', 'Things I like', 'Dislike' and 'Important for me'. This showed the provider took a personalised approach when responding to peoples care and support.

We found each person had a current care plan. Care plans included sections on communication, medication, mental health personal care and mobility. People told us they were supported by staff that were experienced, trained and responded to the changing needs in their care. Staff had a good understanding of people's individual and collective needs. For example, one person who lived in the home told us, "They sort stuff out when I ask." They take me out."

We saw a referral to a speech and language therapist had been made. This was to develop a shared means of communication between the person and their staff team. On the day of our inspection, the speech and language therapist visited to start work with staff on positive communication. This would ensure staff gained the views of the person they were supporting.

We also saw some good examples of risk management plans. The plans showed evidence of capacity assessments and how to respond and support people if they displayed aggressive behaviours. For one person the plan identified the risk, how this was managed, the signs to look for and the steps to follow. This showed the management team had strategies to support staff to respond appropriately.

However not all care plans identified the support people required with their daily routines and personal care needs. For example, in one plan we saw a person had bought themselves a wheelchair that they needed to use when they went out. The person only required the wheelchair sometimes, depending upon their health. However, we found there were no instructions in the care plan on how and when to use the wheelchair safely. They required support with moving and handling. There were no personalised guidelines on how to support the person. They required support with a daily intimate personal care task. There were no personalised guidelines available to instruct staff on how to support the person. We spoke with a member of the management team who told us a visiting health professional had visited and instructed staff on how to complete the procedure. However, there were no guidelines for reference or to guide any new staff.

We saw guidelines in some care records for people who lived at the home contained contradictory information. In one section of a care plan, it detailed the person liked to go for a walk down the promenade or to the local betting shop. We also noted in their records staff could watch them go to the shops and come back themselves. However, the care plan stated the individual did not have any road safety and the individual should be accompanied. Staff had additionally recorded the person had no regard for traffic and

may stop in the middle of the road to rest. The two shops the person regularly visited meant they had to cross one or two roads. This showed care planning contained contradictory information and did not clearly inform staff about how to respond to people's requirements.

This was a breach of Regulation 17, Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not maintain an accurate and complete record of the care provided to instruct staff and minimise risk.

We saw records showed people who lived at the home were involved in the recruitment of staff. We were told people had been on the panel when interviews had taken place. A member of the management team told us, "[The person who lived at the home], had interviewed three ladies for the job, and chose who she wanted. She was really excited." This showed the provider had listened to, responded and respected people's preferences with regard to staff recruitment.

We spoke with people about activities. One person told us, "I have a keyworker, she takes me out sometimes. We went to Lancaster for a coffee once." They also told us they like to go to the pub for a meal, "Usually burger and chips." Every person had a keyworker whose role 'with agreement, was to act on behalf of the person they were assigned to. This included support with care plans, personal files and the person's rights.' A second person told us they visited a relative regularly, and their relative visited them. They said staff arranged transport to and from the relative's home. This showed the provider helped people to maintain positive relationships.

One person attended an evening social club each week and attended a luncheon club at the local church. Other people from Holywell Home had attended this previously but had chosen to stop.

Three people who lived at the home could go out by themselves. They visited local shops and cafes together. A member of staff told us people were well known in the local community. A relative commented, "Because they know them, the local cafes and shops are very protective of everyone who lives here." The provider told us, 'People never used to have access to their own money. We asked if people wanted support to help manage their own money. After a lot of support people are able to go to the bank on their own with their bank book, withdraw money and bring it home." This showed the provider listened to people and had supported people to develop additional skills.

One person told us they were due to go on holiday to Blackpool. They told us they were looking forward to it. Everyone who lived at the home was going whilst the home was being decorated. A member of staff confirmed the holiday was soon. They also told us about previous holidays to Blackpool, "Everyone enjoys themselves. It's a change of scenery and there is a lot for people to see and do."

An up-to-date complaints policy was visible on the notice board. Staff could describe how they would deal with a complaint. We were told they would speak with the deputy manager, manager or provider. People we spoke with told us they were happy and had no complaints about the home. One person told us, "If I did have any problems I would go to the deputy manager." One relative told us, "I am annoyed that I have nothing to complain about." We saw documentation relating to one complaint. The provider had written to, and met the complainant. They had responded to all complaints in line with company policy.

Inadequate

Is the service well-led?

Our findings

Relatives and staff felt the management team were supportive and approachable. One staff member told us, "[Member of the management team] is really, really good, they talk to us like we are human." A second member of staff commented about the management team, "They are absolutely brilliant, you can ask them anything. They are there when you need them." A relative told us, "They've got good staff. They don't leave. That's a good sign."

Holywell Home did not have a registered manager. There was a new manager who was applying to become the registered manager.

During our inspection, we noted safeguarding incidents had gone unreported. The provider had not completed the necessary notifications that related to these incidents. The provider had discussed the incidents with CQC and the local authority but not submitted the relevant notifications. This showed the registered manager had not fulfilled their regulatory responsibilities. The provider had not reported safeguarding incidents to CQC as required.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2009 because the provider had failed in their duty to notify CQC about events they were required to.

Staff were motivated and supportive towards people and each other. One staff member told us," The team is really good." A second staff member said, "Holywell Home, it's a brilliant place, we try our best." Staff told us the provider was supportive to them and listened to their concerns. We were told by a member of staff about a recent issue where the provider had taken control, investigated and resolved the matter. This showed the provider had shown good leadership and supported the staff team.

Staff told us there were regular staff meetings. This enabled the provider to receive feedback on the home delivered and to support and develop staff. It also gave a forum for staff to discuss any issues or concerns. Documentation we looked at showed discussions had included paperwork at the home, maintenance and feedback forms sent to families.

We found the provider had sought views on the care provided, from people who lived at the home and their relatives. For people who lived at the home, easy read documentation was used to gather their views on their care. Three people had told staff they were happy to live at Holywell Home. One person was unable to share their views and one person sought a more independent lifestyle away from the home.

Families had been asked about the care their relatives received. One family had responded and expressed they were happy with the care given. We spoke with a second relative who told us they had received the feedback form to complete. They told us they had not yet filled in the form but had no complaints about the care their family member received.

The provider had procedures to monitor the quality of the home being provided. The management team had completed regular audits. There was a system to record weekly and monthly audits. These included monitoring the environment and equipment, maintenance of the building, infection prevention, reviewing care plan records and medication procedures. However through the inspection, we noted concerns about the staffing arrangements for providing one to one support and how risks to people who lived at the home were managed and recorded. We found that safeguards made in peoples' best interests had not been followed in every case. Robust systems were not in place to monitor and mitigate the risks to people who lived at the home.

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

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not take effective preventative action to keep people safe. Regulation 12 (1) (2) b, d

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain an accurate and complete record of the care provided to instruct staff and minimise risk. Regulation 17 (1) (2)(c) Suitable systems were not in place to monitor and mitigate the risks to people who lived at the home. Regulation 17 (1) (2)(b)

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed in their duty to notify CQC about events they were required to. There were four incidents not reported to CQC. Regulation 18 (1)(2)(e)(5)(iv)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was enough staff to respond to the changing needs and circumstances of people requiring support Regulation 18 (1)(2)(a)(5)(b)

The enforcement action we took:

Warning Notice