Autism Care (North West) Limited

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Inspection report

Autism Care North West Limited
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Ratings

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

Overall summary

Autism Care North West is a private company part of Autism Care UK Limited and currently has six supported tenancies in the North West, supporting individuals with learning disabilities or autistic spectrum disorder within the community. Each supported tenancy is managed on a day to day basis by a support team leader and is provided line-manager support by the registered manager. 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.

Summary of findings

The service is currently registered to provide Personal Care. This service has not previously been inspected as it is a new service. The inspection of the service took place across two dates; 19th & 30th October 2015. The registered manager was given 48 hours' notice prior to the inspection so that we could be sure they would be available to provide us with the information we required.

We found that people's health care needs were not appropriately assessed therefore individual risk factors had not been fully considered, placing people at risk of avoidable harm. Quality assurance systems at the home failed to identify or resolve associated risk, therefore placing people at significant risk of harm.

We looked at care records and found significant gaps in reviews of people's needs. Care plans were not helpful in understanding people's needs, likes and dislikes and daily activities.

We found insufficient evidence of staff training in medicines administration. Quarterly competency assessments for administration of medicines was not evidenced as stated in the medicines policy.

The principles of the Mental Capacity Act 2005 (MCA) had not been embedded into practice and we identified concerns relating to how people's mental capacity had been assessed prior to asking people who use the service to consent to care.

Staff were not provided with effective support. Supervisions were not always undertaken with staff and no appraisals had been completed.

The service had recruitment policies and procedures in place. Employees were asked to undertake checks prior to employment to ensure that they were not a risk to vulnerable people. The documentation for some staff was not available when requested.

We did not find evidence of robust management systems in the home and quality assurance was not effective in order to protect people living at the service from risk.

We observed people being supported and saw that staff interacted with people in a kind and caring way. Staff understood the needs of people they supported and it was obvious that trusting relationships had been created.

We found that peoples individual social care needs were not always being met. We have made a recommendation in respect of this.

We did see some good personal preference information within peoples medicines records.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to person centred care, safe care and treatment, safeguarding people from abuse, valid consent and good governance.

We also found a breach of the Care Quality Commission Regulations 2009 in that the service had failed to notify us of required incidents.

You can see what action we told the provider to take at the back of the full version of this report.

We have deemed that the overall rating for this service is inadequate. This means that it has been placed into 'Special measures' by CQC.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12

Summary of findings

months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not appropriate or effective systems in place to identify the possibility of risk and to prevent harm to people using the service.

Staff were not provided with appropriate training to give medicines safely.

Recruitment systems were not robust to ensure the safety of people using the service.

Staff had a good understanding of safeguarding and were aware of how to report safeguarding concerns.

Is the service effective?

Requires improvement

The service was not effective.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005.

Supervision and appraisals for staff were not always completed and staff were not well supported in their work performance.

People who lived at the service were able to contribute to menu planning.

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

We saw that staff had good skills to communicate with people on an individual basis.

We saw that staff interacted with people in a kind and caring way.

We saw staff treat people with dignity and respect.

However relatives told us: "There is no caring or enthusiasm from the staff".

Peoples independence was restricted due to staffing.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not reviewed when they had experienced a change in circumstances.

Care planning at the home was inadequate. Care plans did not always reflect people's current needs.

People and their relatives said they knew how to raise a complaint.

Summary of findings

Staff understood people's individual needs and we saw that person centred care was central to their support services

Is the service well-led?

Inadequate

The service was not well led.

People were put at risk because systems for monitoring quality and safety were not robust and were ineffective.

The information from risk assessments was not used to manage the risk effectively.

Policies and procedures were in place but were not always adhered to.

Autism Care (North West) Limited

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 service, and to provide a rating for the service under the Care Act 2014.

The inspection team comprised of two compliance inspectors one of which was the lead inspector for the service.

Prior to this inspection, we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us. We received feedback from social work professionals and a community nurse with the learning disabilities team. Their feedback is included within this report.

At the time of our inspection of this location, 22 people used the service. We spoke to five people who used the service and four relatives. This enabled us to determine if people received the care and support they needed and if any identified risks to people's health and wellbeing were appropriately managed.

We observed how staff interacted with people who use the service and viewed four peoples care records. We spoke to four care workers, the registered manager, the service delivery director, the quality assurance facilitator and the operations director during the course of our inspection.

We also looked at a wide range of records. These included; the personnel records of six staff members, a variety of policies and procedures, training records, medicines records and quality monitoring systems.

Inadequate

Is the service safe?

Our findings

We asked people who lived at the service if they felt safe. People told us: "I have lived here a long time, I feel safe". "Yes I feel happy and safe". And: "Yes I always feel safe".

We looked at how the service supports people to apply their prescribed topical treatments such as creams and ointments. Staff told us they applied topical treatments for people; however, clear directions of where this should be applied were not recorded.

We looked at people's care plans and found gaps in information regarding people's medicine regimes. Care plans we looked at were out of date and did not have all current medicines listed. This placed people at risk of not receiving their medicines as prescribed.

All of the people who use the service had their medicines administered by care staff. Staff told us they had all completed the appropriate training in medicines management during their induction. However, when we looked at training records we found that 20% of staff had medications training that was out of date by two years. A further 28% had no certificate to evidence they had completed the training. Quarterly staff competency assessments for administration of medicines were not evidenced as stated in the medicines policy.

These shortfalls in medication arrangements amounted to a breach of breach of regulation 12 (2) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service protected people from avoidable harm. We found that risk assessments were not always up to date. Where risks had been identified, care planning around the associated risk was not recorded. In some examples no action had been taken to manage the risks, which meant people were not safe. For example, we reviewed one person's care file and found that medical information about nutrition had not been included in the risk assessment or care plans. This put them risk of harm. Another example was that of two accident forms completed for the same person for falls. Following the first fall in September the incident was not risk assessed and the service did not use the information to ensure that preventative measures were put into place. A second incident was then reported; we felt that if sufficient precautions had been considered at the time of the first incident, this could have prevented further instances that placed the person at risk of harm and injury.

Risk management at the service was found to be inadequate. This amounted to a breach of Regulation 12 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and relatives informed us that people who use the service contribute to staff expenses. For example purchasing lunch for staff who support them. We did not find any agreement from people who used the service relating to this contribution within the care files. This could leave people at risk of financial abuse. Internal audits had highlighted the need for this to be completed in line with the service policy.

This lack of agreement resulted in a breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the quality assurance audits and found that smoke alarm testing had not been completed at all the properties. In one house fire door checks had not been carried out since February 2014.

Under current fire safety legislation it is the responsibility of the registered manager to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan (PEEP) needs to be completed for each individual living at the home. People who use the service did not have copies of PEEP's in their care files. When we asked to see a copy of these in one of the homes, we were told that people who use the service did not have them in place.

We saw that water temperature checks were completed daily. There were four incidences over a ten day period where the water has exceeded the limits suggested as `safe`. No further action had been taken. We did not see an action plan to address the concern. This could have a serious impact on residents and staff who were at risk of possible scalding and/or burns.

The above fire and water safety omissions amounted to a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We looked at recruitment processes and found the service had recruitment policies and procedures in place. Employees were asked to undertake checks prior to employment to help ensure that they were not a risk to vulnerable people. However when we looked at six staff recruitment records we found that two staff did not have disclosure and barring service checks (DBS) on the record. One of the files looked at contained no pre-employment checks and no completed application form, clearances, references or identification checks were in place.

The failure to complete required checks and paperwork to keep people safe was a breach of regulation 19 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We visited three out of six houses that supported people living with learning disabilities. We looked at training records and found that 23 out of the 24 staff members had received safeguarding training. The service had procedures in place for dealing with allegations of abuse.

We found that staff were able to tell us about safe guarding principles and recognised signs of abuse. One staff member told us "I understand about types of abuse. I feel confident to tell my manager and I have access to the local authority's contact number to report abuse". Another staff member told us "We receive safeguarding training on induction, and regular updates. I understand how to report abuse and know it is everyone's responsibility to protect people who live here". We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

We asked staff if they felt there were sufficient numbers of staff to provide care and support for people living within Autism Care Northwest. One staff member told us: "Yes I feel staffing is ok, however I am not happy with the limited hours of one to one time people get. It isn't enough". Another staff member told us: "The house is safe with these staffing levels, but the level of outdoor activities isn't enough because we do not have the spare staffing hours".

Relatives we spoke to were frustrated with the change to one to one hours and the implications this had on the care provided. We spoke with the registered manager who explained that one to one hours were determined by funding commissioned by the local authority. We asked the registered manager if any monitoring of this had been undertaken in order to enable a review of people's needs by the local authority. The registered manager told us that this had not been achieved.

We asked the registered manager how staffing levels were determined. The registered manager told us that social services were responsible for allocating hours per week for each individual that resides within the service. The registered manager agreed that one to one hours, which should enable people to lead a fulfilled life, were not sufficient. This had a negative impact on the independence of people who use the service.

We looked at how the service provided a safe environment for people. A relative told us "the home is always clean and tidy". We visited three houses where people were provided with support. We found that houses were clean and well designed. People had space to maintain their independence and adaptive designs such as handrails and bath hoists were in place where required.

We looked at house cleaning records and found that these were completed most days. One person who lived at the service told us "I like to help to clean the house". Staff told us that people who lived at the service were encouraged to take part in house chores to maintain their life skills and independence.

Each medicine record had a front sheet with a picture of the person and a list of their current medicines and the side effects. In addition, there was information about where the person likes to take their medicines and with which drink and consent for the staff to administer medicines. This level of person centred detail was positive.

Controlled medicines were kept separate in a secure cupboard; records for these medicines were completed in full. Controlled medicines are those which are covered by the misuse of drugs act legislation. A daily audit was carried out for each medicine to reconcile administration with remaining stock.

Requires improvement

Is the service effective?

Our findings

We asked people who lived at the service if they felt that the support provided met their individual needs. People told us: “Yes I have everything I need”. “Staff even buy me birthday presents”. And: “The staff are very nice; we can do what we want here”.

We observed staff support people who lived at the service. We saw that staff had good skills to communicate with people on an individual basis. We observed one member of staff interact with a person who was agitated; the staff member approached the person in a calm manner and reassured them that everything was ok. We saw that the staff member was confident within their role and understood the needs and preferences of the person.

We asked staff if they received training to help them understand their role and responsibilities. Staff told us: “Yes I had a really good induction, the training was excellent”. “I really enjoy the training days”. And: “Yes I feel we get a lot of training, I really enjoyed the training in managing challenging behaviours”.

We asked staff if they had received training in the Mental Capacity Act 2005. Staff told us: “Yes I have done MCA and DoLS training this year”. “I don’t think MCA was covered in my induction but I did it in my last job”. And: "I am not sure if anyone is on a DoLS but I have done training and understand the basics”. “I don’t know how to refer someone for a DoLS”.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager.

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. We checked whether the service was working within the principles of the MCA.

We looked at care records and found that people who use the service were asked to sign consent records; for example service user agreements. However, we found a lack of consideration for assessment of a person’s mental capacity prior to asking people who use the service for consent to care. In the care files we looked at we saw that mental capacity care plans had been completed however the content did not relate to mental capacity.

The Mental Capacity Act 2005 Code of Practice stipulates: ‘There are a number of reasons why people may question a person's capacity to make a specific decision:

• The person’s behaviour or circumstances cause doubt as to whether they have capacity to make a decision.

• Somebody else says they are concerned about the person’s capacity, or

• The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.’

As this service provides personal care to individuals with learning disabilities or autistic spectrum disorder there is an indicator to complete capacity assessments.

The registered manager sent us copies of completed MCA assessments for one of the properties we did not visit. These assessments showed a good standard of recording and sufficient understanding from the staff member who had completed. However we found that a lack of consistency throughout the service meant that not all people had been assessed in line with the MCA 2005. There was a lack of consistency across the different supported tenancies in staff training. This was also evidenced within the staff training matrix, out of the 25 staff members 13 had not completed training in DOLS and seven had not completed MCA 2005 training.

This failure to follow the code of practice amounted to a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

We saw that each supported living house had a kitchen area that people could access. We observed lunch being prepared and served in one house and saw that people enjoyed their meal of cheese on toast.

People who lived at the service told us: “Yes I love the food”. “We get loads of choice”. And: “We do weekly menus, I love the food”.

We saw that one person had been supported to a bake cake and they were enjoying it as an afternoon snack. Snacks were available as and when people wanted. We looked at weekly menus and found that people who lived at the service were able to contribute to menu planning.

A member of staff told us that one person was not eating well. We asked the staff member if they were able to weigh the person and monitor their weight if this was needed. The staff member told us that they did not have any weigh scales and despite the staff identifying that the person looked to have lost weight, no weight management plan had been initiated. The registered manager provided information following the inspection that weighing scales had been purchased and were being utilised.

People were sufficiently supported to maintain their physical and mental health. Staff escorted people to appointments and maintained contact with community professionals. The information following these appointments were not always updated within the care files.

We looked at supervision and appraisal records and found significant lapses in time. Fourteen out of twenty-five members of staff had had at least one supervision. The highest total number of supervisions undertaken for an individual staff member was three. The provider's supervision policy stipulated it was the line manager’s responsibility to arrange supervision on a regular basis to ensure a minimum of six per twelve month period were undertaken. We found that this had not been achieved for all staff members.

The provider’s appraisal policy stipulated staff would receive annual appraisals. However, records demonstrated that none of the staff had received an annual appraisal. The registered manager told us that they did not hold any formal supervision or appraisals for team leaders.

We asked staff if they were able to tell us when they last had supervision. Staff told us: “I have never had supervision”. “I had one years ago”. And: “I had one a few months ago, the new team leader is good but we have a high turnover of managers and this one is due to leave”. Staff were not well supported in their work performance.

These shortfalls in supervision of staff amounted to a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

We observed people being supported at three houses. We saw that staff interacted with people in a kind and caring way. Staff understood the needs of people they supported and it was obvious that trusting relationships had been created.

We received some positive comments about the staff and about the care that people received, such as: “Staff are capable and nice”. And: “I am confident in the care provided by the staff”. However not everyone was positive about the staff and the care people received. One relative described the service as: “A babysitting service”. And: “There is no caring or enthusiasm from the staff”.

We asked people if they felt involved in their care and support. One person told us: “Yes I think so, I am ok”. And: “Everyone is nice to me, they know me”. One relative said: “The staff contact me with information and keep me updated”. One relative told us that the staff had helped the relative and loved one to plan for the future and for end of life care.

The home had policies and procedures that covered areas such as confidentiality, privacy and dignity. We saw that staff were aware of these and were implementing them when supporting people.

We saw that people had individual bedrooms that had been personalised. People had their own space that facilitated privacy and independence. People told us that that they were happy. People’s individuality was maintained and they were able to maintain their independence within the homes we visited.

During the inspection, we saw staff treat people with dignity and respect. We observed staff knock on people’s bedroom doors and bathroom facilities were lockable to enable people to feel that their dignity was protected. One person told us: “I love my bedroom; I have my own bathroom too”.

A professional who visits one house told us: “There are a lot of locked doors in the home”. This restricted the movements and independence of the people who live at this home. In particular, it had a negative impact on one person who uses the service. The professional had advised the staff at the home to open up the spaces.

A relative told us: "There is only ever one staff member on and due to the home being mixed abilities it restricts what they can do”. And: “Independence is affected due to the staffing”.

We have therefore judged that people’s individual social care needs were not being met. We would recommend that the service follow recommended guidance such as NICE in respect of meeting people individual social care needs.

Requires improvement

Is the service responsive?

Our findings

People told us: “I love it here”. And: “Yes I like living here”.

We saw that people had their own personal spaces and these had been personalised. One person invited us into their bedroom, we saw individual items that represented the person and they told us: “Yes it is my home”.

Another person had sensory equipment in their bedroom, which had been purchased for their own specific needs. Staff told us that the person’s bedroom was designed to enable their safety. However there was no risk assessment or care plan to support the adaptations and equipment within the care file.

We observed staff interact with people who lived at the service. Staff providing support understood people’s individual needs and we saw that person centred care was central to their support services.

Staff told us that they did not write or review people’s care plans. This was the responsibility of the team leader at each house. However, we saw good examples of person centred support during interventions that could be effectively care planned by staff who provide day and night time support.

Information within the service was not always available in different formats despite people having a variety of needs, which meant people might not understand their care plans or complaints procedures. In one house, we saw that signs had been wall mounted to show people how to make a complaint. These were small print and the pictures were not easily identifiable.

People told us that staff supported them to go out for lunch. One relative said: “The staff have taken [name removed] to the Blackpool illuminations and to the safari park”. However, another relative complained that there was not enough staff to support people to engage in activities. Staff told us they did not have enough hours to support people with outdoor activities. Only one of the homes had access to a vehicle. Therefore, people were not always supported to access the community.

We reviewed four people’s care plans. Many care plans were historical and had not been updated one person had care plans last updated in 2013. The person recently has had a change in their mobility and has fallen three times in the last seven months. The service had failed to appropriately respond to the person’s change in needs or manage risks associated with their needs.

Another person had care plans in place for mealtime routine, food and sugar levels. The most recent update on these care plans was 2013. However, information gathered post inspection highlighted that this person visited her GP in September 2015 for a diabetic health review. They were advised to eat higher calorie foods. This was not updated in the care plans.

We found that the registered person has not protected people against the risk of unsafe care or treatment, because care planning and assessment processes were not always sufficiently person centred and potential risk had not always been well managed. Care plans were not helpful in understanding people’s needs, likes and dislikes and daily activities. Therefore, staff who did not know people would have found it challenging to provide person centred care to people who often found it difficult to communicate their needs.

This amounted to a breach of Regulation 9 (1) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence that showed the views of people who use the service had been sought following a change in service from residential to community supported living for some people. This has been a recent transition, which required monitoring to ensure continuity of care.

There was a complaints procedure in place. One relative told us: “When I have complained I’ve met with the registered manager to discuss concerns and initially I think he understands but then nothing changes”. Another relative said: “I would feel comfortable in raising a complaint if the need arose “.

Inadequate

Is the service well-led?

Our findings

We asked staff if they felt supported by the registered manager. Staff told us: "I don't really see the manager". "The manager is a nice person, but he doesn't come around often". And: "I can't remember the last time I saw the manager".

Staff told us team leaders were always available and spoke highly of them. Some staff commented they didn't see the registered manager on a regular basis but told us support was available from other managers in the organisation.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These were reviewed and updated regularly and covered areas, such as The Mental Capacity Act, Deprivation of Liberty Safeguarding, medicines, appraisal, staff supervision, individual planning and review and health and safety. However, our finding throughout the inspection demonstrated that the service were not always following their own policies and procedures.

Prior to our inspection, we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We found that we had not been notified about things we needed to know. For example, one person living at the service had been in hospital following a fall where an injury was sustained, this is classed as a reportable incident.

We found that incidents had not been referred to the local safeguarding team and the Care Quality Commission did not always receive notifications.

This resulted in a breach of Regulation 18 (2) (a) (b) CQC (Registration) Regulations 2009.

We found that the service had systems in place to monitor the delivery of care; however, the systems were inadequate to ensure the delivery of high quality care. During the inspection, we identified failings in a number of areas. These included person centred care, premises safety, managing risk to people and nutrition. We saw some records of audits that had been completed; however these issues had not been sufficiently identified or managed by the registered manager prior to our visit which showed that there was a lack of robust quality assurance systems in place.

We looked at these audit records and found that some areas of concern had been identified. However, the manager was unable to evidence systems put into place to rectify and address the areas requiring improvement. The registered manager explained that he did not have oversight of the audits completed. He was unaware of the issues that had been highlighted within each of the homes. He was aware that there were action plans sent out but he did not oversee the implementation of these.

Accidents and incidents are reported to the main office and the registered manager stated that they did not have oversight of these. The registered manager was unaware of two falls that one person who uses the service had experienced recently. We found that the registered manager had not been responsive to known risks at the service. There were no investigations into the accidents, which meant the service could not learn from error to keep people safe.

The registered manager informed us that they did not have access to a central rota for staffing and could not tell us which staff were on shift. The house team leaders, with no management oversight, arrange the deployment of staff. This meant that the registered manager could not be sure that the correct number of staff were in place to ensure peoples safety.

The shortfalls in quality assurance and risk management amounted to a breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the lack of management oversight at the service had a negative impact on people's support and wellbeing.

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
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not have effective arrangements in place to ensure that the care and treatment of service users was appropriate, outlined to meet their needs and reflected their preferences. Regulation 9 (1) (3) (a) (b). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. We have asked for an action plan to be completed and sent to us detailing any actions the provider is going to take to help ensure they meet this regulation.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) (3) As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. We have asked for an action plan to be completed and sent to us detailing any actions the provider is going to take to help ensure they meet this regulation.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have suitable arrangements in place to protect service users from abuse and improper treatment. Regulation 13 (1) (2). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. We have asked for an action plan to be completed and sent to us detailing any actions the provider is going to take to help ensure they meet this regulation.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. We have asked for an action plan to be completed and sent to us detailing any actions the provider is going to take to help ensure they meet this regulation.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not operate robust recruitment procedures. Regulation 19 (1) (a) (b) As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

This section is primarily information for the provider

Action we have told the provider to take

We have asked for an action plan to be completed and sent to us detailing any actions the provider is going to take to help ensure they meet this regulation.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not always inform us of incidents that require submission of a statutory notification to the Care Quality Commission. Regulation 18 (2) (a) (b) As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. We have asked for an action plan to be completed and sent to us detailing any actions the provider is going to take to help ensure they meet this regulation.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users.** Regulations 12 (2) (a) (b) (c) (d).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We have issued a warning notice in respect of this breech of regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service provider must ensure that there is a robust system in place that can monitor the quality of service provided.** Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We have issued a warning notice in respect of this breech of reguation.