Miss Margaret Clark Stevenson

The Trio House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Trio House is located in Hereford, Herefordshire, The service provides accommodation and personal care for three adults who are living with learning disabilities, autistic spectrum disorders and complex health needs. On the day of our inspection, there were three people living at the home.

The inspection took place on 13 December 2017 and was unannounced.

There was not a requirement to have a registered manager at this home. The home was managed by the registered provider. Registered providers and registered managers 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.

At our previous inspection in December 2015, we rated this service as 'Good.' At this inspection, breaches of Regulation were identified. These were in relation to safeguarding people from abuse or improper treatment; the need for consent; receiving and acting on complaints; good governance; staffing; failure to display the ratings; and failure to notify the CQC of incidents involving alleged harm or abuse.

Allegations of abuse or harm had not been investigated effectively or appropriately. Allegations of abuse or harm had not been shared by the provider with the local authority, the police, or with the Care Quality Commission. This had placed people at risk of continued abuse or harm. he provider and staff did not understand their roles and responsibilities in protecting people from abuse or harm.

There were no contingency plans in place to cover staff absences. There were no structured induction programmes for staff. Inexperienced and untrained staff were placed on duty to care for people, despite not having the knowledge needed to safely meet their needs.

Whilst staff had received training in some key areas of their practice, they had not been trained in all relevant aspects, such as moving and handling. Staff did not receive ongoing supervision in their roles.

People had been unlawfully deprived of their liberty, The provider was unaware of their responsibilities in regard to the Mental Capacity Act.

People's confidential information was not always kept secure.

There was no system in place for capturing, investigating or responding to complaints. The provider had mechanisms in place to continually monitor and review the quality of care provided. Where the provider had policies and procedures in place, these had not been followed.

People received their medicines safely. People were protected from the risk of infection.

Staff and the provider knew individuals well and understood their styles and methods of communication. People's changing healthcare needs were responded to.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.

Services in special measures will be kept under review; if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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 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.

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.

Significant and multiple allegations of abuse and neglect had not been reported to the police, local authority or to the CQC. The provider and staff did not fully understand their responsibilities and role in regard to protecting people from abuse and improper treatment.

There were no contingency plans in place to ensure there were sufficient numbers of experienced and suitably qualified staff.

People received their medicines safely.

Is the service effective?

Inadequate

The service was not effective.

People had been unlawfully deprived of their liberty. The provider was unaware of their requirements under the Mental Capacity Act.

There was no formal induction programme in place for new staff. The provider had no training in key areas, such as safeguarding.

Is the service caring?

Requires Improvement

The service was not always caring.

People's confidential information was not always stored securely.

Staff knew people well as individuals. People were relaxed and comfortable in staff and the provider's presence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no system in place for capturing and responding to complaints and feedback. Care plans were not always reflective of people's current needs.

Staff understood people's needs and preferences,

Is the service well-led?

Inadequate

The service was not well-led.

There were no quality assurance systems in place to monitor, review and improve the quality of care provided. The provider had not notified the CQC of significant allegations of abuse and harm, which they are required to do by law

There were no audits of key areas such as medication and risk assessments, which had the potential to compromise people's safety.

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

We made an unannounced inspection on 14 December 2017. The inspection team consisted of two Inspectors.

We looked at the information we held about the service and the provider. We asked the local authority for information about any concerns they had about the quality of care provided to people. This information helped us to focus our inspection.

We observed how staff supported people throughout the day. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered provider, the deputy manager and two members of care staff. We looked at three care plans, which contained information about people's healthcare needs; risk assessments and communication styles and preferences. We looked at two medication administration records; six staff pre-employment checks; accident and incident records; internal safeguarding records; staff rotas over a four week period; the provider's policy on protecting people from abuse, and the provider's whistle-blowing policy.

Inadequate

Is the service safe?

Our findings

At our previous inspection in December 2015, we rated this key question as 'Good.' At this inspection, we found systems in place for investigating allegations of abuse were not effective. We also found staff were not deployed safely, with inexperienced and untrained staff caring for people.

Prior to our inspection, we received information of concern about people living at Trio House being subjected to abuse, harm and neglect. During our inspection, we found six significant allegations of abuse and harm had been raised with the provider over a period of four months. These included allegations of neglect; verbal aggression and intimidation; theft of people's belongings; and people being cared for by staff who were unsuitable to work in care. Whilst the provider had taken steps to investigate these matters internally, resulting in the dismissal of the alleged abusers, they had not informed the police, the local authority, the alleged victims' families, or the Care Quality Commission. The provider had also not suspended staff whilst investigations were ongoing, which meant the alleged abusers continued to care for people. The provider told us, "I thought I had to investigate it myself and try and find proof. I didn't have enough proof for all of it, so I thought I couldn't do anything." Because the provider had failed to notify the relevant authorities, this meant the allegations of abuse had not been investigated formally and resulted in a lack of action to taken to prevent people from further abuse or harm.

The provider did not know that all allegations of abuse or harm, rather than proven abuse, have to be reported to the local authority and to the Care Quality Commission. The provider told us they were unaware of their requirements in this regard as they had not been trained in safeguarding. The provider also told us they had struggled, at first, to believe one of the allegations about a former member of staff because, "They had worked here for such a long time, I just never thought they would do that." This was despite the provider being aware that at least two people living at the home had been affected by the alleged abuse. The provider told us about changes in people's behaviours and how they had shown signs of distress during the period of the alleged abuse.

Staff we spoke with told us they had either witnessed abusive practice in the home, or were aware of allegations of suspected abuse. This had included former members of staff taking people out for the day, but had then left them in the care whilst staff attended to their own personal affairs. The provider told us they had '"caught staff out" a couple of times where they said people had gone out in the day, but had not. The provider told us they could also tell from one person's behaviours they had not had the stimulation they needed that day. The provider told us, "I can tell when [person] has been out and enjoyed themselves as they are always tired that evening; tired, but happy. But I noticed [person] was restless, even though staff said [person] had been out all day and enjoyed themselves." One person living at the home lived with an autistic spectrum disorder, which meant their routine was very important to them. The provider told us because this person's routine had not been adhered to and the person had not had the stimulation they needed, they had displayed heightened behaviours and had physically demonstrated their distress.

Whilst staff told us they had raised this concern with the provider and the deputy manager, staff had not escalated these concerns further to ensure the safety of people living at Trio House. Staff told us they were

aware they could have escalated their concerns to the local authority and the Care Quality Commission, and should have done so. This did not demonstrate a full understanding of their responsibilities in regard to safeguarding people from abuse and improper treatment. We discussed this with the provider, who told us, "It's been a wake-up call for me. I know I have to understand my responsibilities." The provider told us they realised they had made "the wrong decisions", and that they would learn from these mistakes. After our inspection, the provider accepted the local authority's offer of safeguarding training for all staff. However, the provider had not formally notified the local authority or the Care Quality Commission of the alleged abuse or harm one week after our inspection. We subsequently contacted them to remind them of their responsibilities in this regard.

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

At the time of our inspection, the provider had two vacancies for two full-time care staff. This meant that all current shifts had to be covered by the existing staff team of six staff, one of whom had no prior care work experience or training and had worked at the home for less than a week. Another member of staff was only available to work weekends. This meant that only four of the six members of staff were available to be placed on the rota in the week. The levels of staffing at Trio House had been determined by the provider as two carers in the morning, two in the afternoon and evening, and one member of staff at night. One person living at Trio House needed 2:1 support when going out into the community, and 1:1 support with eating and drinking. We saw from the staff rotas that there were no contingency plans in place to cover shifts in the event that staff were unwell or absent from work. One member of staff was due to cover three 13 hour shifts in succession, and had been routinely working 15 hours' in excess of their contracted hours. They were unable to take any time off work during this period. The provider told us, "The staff do need a break, they have all been working so hard to cover the shifts."

We asked the provider what would happen in the event this member of staff could not work. The provider told us they would have to ask a new member of staff to cover this shift. However, this member of staff was new, had no experience of working in care, was not trained and was unable to administer people's medicines. Therefore, it would not be safe working practice for this staff member to cover shifts. The provider did not use agency staff, and was reluctant to do so. They were unable to provide assurances to us as to how they intended to staff the home safely.

Following our inspection, the local authority supported the provider to contact a local care agency and arrange for eight shifts to be covered in the next two weeks. The provider requested for the same carers to be supplied by the agency so that people living at Trio House had consistency with people caring for them.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before new staff started work at Trio House, the provider had carried out reference checks and checks with the Disclosure and Barring Service (DBS). However, the provider was aware that two former employees, both alleged abusers, continued to work in care. The provider had not informed the DBS of this, and was unaware of the fact they should notify them. We explained to the provider they had a duty to protect other vulnerable adults from abuse or harm, not just those living at Trio House. We checked with the provider one week after our inspection, and they had still not informed the DBS.

Staff who administered medicines demonstrated a good knowledge of people's care needs and confirmed they had received training in the safe administration of medicines. They stated they had also received

competence checks from the provider and from the pharmacy. However, there was no documentation to confirm competencies checks had been undertaken.

We checked people's medicine records and looked at the medicine storage arrangements. The provider had systems and procedures in place that reflected good practice. We found that all the medication records we looked at had photographs and recorded people's allergies, which reduced the risk of medicines being given to the wrong person or to someone with an allergy and was in line with current guidance.

Prescription medicines that are controlled under the Misuse of Drugs legislation) were stored as per legislation. Medication administrative record charts (MAR) were correct for each transaction. During our inspection, we identified that one person required the administration of PRN medication, this is medication given as and when required. Information was available to guide staff when administering such medicines, which were prescribed in this way.

During our inspection, we observed people being cared for safely. This included being assisted to eat and drink and to move around the home. We observed people's emotional needs being responded to, with staff being able to soothe people who needed reassurance when they displayed signs of anxiety.

The physical environment was safe for people. Recent fire safety checks had been carried out by the fire service, and they had found the home to be meeting the fire safety requirements. People were protected from the risk of infection. Daily cleaning schedules were in place to ensure high standards of cleanliness were maintained in the home. Staff had received training in infection control, and understood its importance.

Inadequate

Is the service effective?

Our findings

At our previous inspection in December 2015, we rated this key question as 'Good.' At this inspection, we found the provider was not adhering to the principles of the Mental Capacity Act and that people had been unlawfully deprived of their liberty. We also found that staff and the provider had not received training in key areas of their practice, including safeguarding and moving and handling.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

People living at Trio House required 24 hour care and supervision. They were unable to leave the home by themselves, should they wish to do so. People's finances were managed by staff and they were not in control of these. Although these were restrictions on people's liberty, the provider had not made any applications for DoLS authorisations. They were unaware of their requirements in this regard, telling us, "No one had ever told me to apply for DoLS. I didn't know that I was expected to do it." This meant people had been deprived of their liberty, and were at risk of having their liberty further deprived, without lawful authority. The local authority told us they would support the provider as a matter of urgency to complete the necessary DoLS process for people.

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

The provider and staff did not demonstrate an understanding of the key principles of the Act. For example, one person's care plan stated, "[Person's] appointed bed time in the week is 10pm, but they can stay up later on weekends." We asked the provider if people had set bedtimes and they told us, "Yes and no." They explained that some people needed to go to bed at certain times in the week due to feeling tired. We explained that people need to be given as much choice as possible , and that determining bedtimes for people was not reflective of current best practice. Set bedtimes for people was not reflective of the key principles of the MCA. If this decision had been made in the person's best interest, the best interest decision-making process should have been followed. This process involved having a formal and documented discussion with relatives, health professionals and the person's advocate, if applicable. Best interest decisions should be specific to people's individual needs. The provider recognised the need for additional training and guidance in this area, and told us they would seek guidance from the local authority.

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

The provider and staff were not fully trained in, or aware of, key legislation or principles which underpinned their daily practice. The provider was not aware of current safeguarding processes, which was reflected in their adult protection policy, which made reference to historical regulatory bodies. The provider told us, "I have not been trained in safeguarding at all." We saw how the provider's lack of training in, and understanding of, safeguarding resulted in alleged abuse or harm not being investigated appropriately. The provider also did not demonstrate an understanding of the Mental Capacity Act and their responsibilities in this regard.

There were no formal induction processes in place for new members of staff. When new members of staff started, they were given a tour of the home and the daily tasks were explained to them. They worked alongside existing staff for a one week, and were then placed on the rota. At the time of our inspection, one member of staff had worked at the home for three days; they had no experience of working in care. We saw from the rotas that this member of staff was classed as being on duty, despite having no training, experience or background in care. This placed people at risk of harm as they were cared for by someone who did not know how to meet their needs safely and effectively. The provider did not use the Care Certificate as an induction tool. The Care Certificate is a set of nationally recognised standards which care workers must adhere to in their daily practice. We explained to the provider the importance of structured inductions for new staff, particularly where they had no experience of caring for and working with vulnerable adults with complex needs.

Staff had received external training in areas such as medicines administration, infection control and epilepsy. Staff demonstrated an understanding of these areas, and were able to tell us were the training had benefited their practice. However, staff had not received training in moving and handling. We spoke with the provider about this, who told us staff did not have to assist anyone living at the home to move. One person living at the home needed 2:1 support from staff when mobilising. The provider told us they did not think of this as moving and handling because the person did not fall to the ground. We discussed the purpose of this training and its relevance to staff's practice with the provider .

Staff did not receive regular formal supervision from the provider or the deputy manager, with no supervision having taken place over the last 12 months. Supervisions are 1:1 meetings between staff and management and are used to discuss training and developing needs and to provide feedback on staff's performance. The provider and staff told us although there was no formal supervision process in place, staff could approach the provider or the deputy manager when they needed to. Staff told us they felt supported in their roles and did not feel a lack of formal supervision had affected their ability to care for people. We discussed the purpose of supervision with the provider. Specifically, they should be used as a way of formally addressing staff conduct issues, as well as training and developing needs. There had been a recent period of four months where the provider had been concerned over certain staff members' conduct, but supervision had not been used as a way of addressing and monitoring this. The provider told us, "I know I have to get better on that side of things."

People were supported to maintain their health. We saw that people had access to a range of healthcare professionals, as required. These included epilepsy nurses, speech and language therapists and GPs. This healthcare information and guidance from professionals was detailed in people's care plans. Staff told us how they recognised signs and symptoms that people felt unwell, and how people expressed feelings of ill-health. One person's health had deteriorated, and we saw the provider and staff had ensured the person was seen by specialist healthcare professionals. Where there were concerns over people's weight, this was

monitored and guidance sought from GPs.

Where people needed specialist diets or help with their eating and drinking needs, this was provided. One person needed to have thickened fluids to prevent choking. Staff knew what consistency the drinks were to be made to, and this speech and language therapy guidance was contained in the person's care plan. Where people needed 1:1 support from staff to help them eat their meals, we saw this was provided.

We saw that people were familiar with the layout and design of their home, and they were able to navigate their way around this with ease. People's bedrooms had been personalised to each individual's taste, and to help people identify which room was their own.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in December 2015, we rated this key question as 'Good.' At this inspection, we found improvements were needed in regard to protecting people's confidential information.

People's confidential information was not always kept secure. We found people's personal financial information in staff personnel and training files, which staff were able to access. We brought this to the attention of the provider. who told us, "I really need to sort all my paperwork out." They removed this personal information from the staff files once we had made them aware.

We saw that staff and the provider knew people well, with people being comfortable and relaxed in their presence. Staff and the provider demonstrated a good understanding of people's individual communication styles and preferences, and they were able to explain to us how each person expressed themselves. At the time of our inspection, there were no links with independent advocacy services. Advocacy serves are used where people need help and support to make their views known. However, staff and the provider told us they advocated on people's behalf. For example, the provider told us they believed one person living at Trio House had not received the medical attention they should have. They told us they were "fighting" for this person's rights, and "would not give up."

We observed respectful and dignified interactions between staff and people. Staff told us they had received training in dignity and respect, and understood its importance in their practice. The atmosphere in the home was calm, relaxed and homely, with people expressing feelings of happiness when spending time with staff. People were encouraged to carry out daily tasks independently, as much as possible. Where 1:1 assistance was needed, this was done in a discreet and dignified manner.

People's care plans showed sensitivity and consideration about issues around equality, diversity and human rights. People's sexual preferences and needs were documented, and there was a non-judgemental approach to these. This helped to promote an inclusive approach within the home, and showed an appreciation of respecting and valuing differences.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in December 2015, we rated this key question as 'Good.' At this inspection, we found improvements were needed in ensuring there was a formal complaints system in place and making sure people's care plans were reflective of their current needs.

Registered providers must establish and operate an accessible system for identifying, receiving, recording, handling and responding to complaints. At the time of our inspection, there was no complaints procedure in place. There was no information displayed for people, relatives or health professionals regarding how they could make a formal complaint, raise a concern or provide feedback. We asked the provider how they captured complaints. They told us they recorded any such concerns in a personal diary. We found that one complaint had been received and logged in the diary, but this had not been responded to. This did not demonstrate an understanding for the need for a complaints procedure and the important role complaint investigation plays in the delivery of good care. The provider told us they would implement a complaints system and ensure this information was made accessible for people, in keeping with the Accessible Information Standard. This standard requires publically-funded bodies to provide information to people about the service they receive in accessible formats, such as audio or large-print.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although individual care plans were in place, these had not been regularly updated to ensure they reflected people's current health and wellbeing needs, as well as people's personal preferences. Information regarding changes in people's needs was recorded, but in more than one place; the provider struggled to locate information from people's care plans during our inspection. Although the existing staff team knew people well as individuals and what their needs were, new staff would need to use people's care plans to help them to understand what support people needed. This was of particular importance as the people living at Trio House used non-verbal communication. The provider told us they were in the process of updating one care plan, as they recognised this was a concern. They told us the remaining care plans would then be updated also.

Staff demonstrated a good understanding of people's individual needs and preferences, such as the need for stimulation and routine. One member of staff told us, "People have plenty of stimulation and are taken out regularly." One person enjoyed doing puzzles with staff, so staff made sure the person was able to do this on a daily basis. One person needed a specific bathing routine. Staff gave detailed responses as to the nature of this routine and why it was in place.

The provider told us they ensured people were part of their local community. Although there were no formal community links with other organisations, we saw that people enjoyed going out to places such as their local leisure centre, with staff support. The provider told us it was important people were not isolated from their community and that they ensured people had plenty of opportunities for going out, as well as visiting neighbouring towns and places of interest.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in December 2015, we rated this key question as 'Good.' At this inspection, we found the provider was not up-to-date in their knowledge of legislation underpinning their practice. Their policies and procedures referred to historical regulatory bodies, as well as out-of-date safeguarding procedures. The provider had not kept informed of current best practice in adult social care, or in adults with learning disabilities and autistic spectrum disorders. This had repercussions for people living at Trio House, such as being unlawfully deprived of their liberty, and receiving care which was not always person-centred.

Where the provider had policies and procedures in place, they had not adhered to these. For example, the provider's adult protection policy stated that where allegations of abuse were made, the correct process was for the provider or staff to alert the safeguarding team, the CQC and other relevant agencies, as necessary. The provider told us, " I feel really stupid now reading this (the policy). I feel I have let people (living at Trio House) down." The provider demonstrated a lack of understanding of the need for whistle-blowing procedures. There was a whistle-blowing policy in place. However, this policy was about the requirements of staff to maintain people's personal care and respect their preferences. It did not set out how staff could escalate concerns about unsafe or abusive practice, which is the purpose of any such policy.

Records associated with people's individual care needs were not always accurate or up-to-date. Although risk assessments were in place, these were identical for each person living at Trio House and looked at risk in relation to the same areas, such as the risks associated with swimming and with going out into the community. Each risk assessment had the same risk score of '25.' We asked the provider what that risk score meant, in practice. They were unsure what it meant and told us, "I have got to update all of these."

The provider told us they had no quality assurance systems in place. This meant there was no mechanism to monitor the quality of care people received, or to monitor their health, safety and wellbeing. Audits were not carried out in key areas such as medication, risk assessments and infection control. This affected the care provided to people. For example, people's risk assessments did not reflect their needs, which meant that new staff had to rely on what other staff told them about how to keep people safe. This put people at risk of not being cared for safely.

Feedback was neither captured, nor used as a way of continually improving the service. There were no mechanisms in place to involve people in decisions about how the service was run, nor of gathering their views or the views of family members, visitors, staff, and health professionals.

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

Registered providers are required by law to notify the CQC of incidents where people have suffered harm, injury, abuse or suspected abuse. The provider had not notified us of the six significant allegations of abuse regarding people living at Trio House. The provider told us they were unaware they were required to notify

us of this, and that they did not know how to submit a statutory notification to us. Statutory notifications are used by the CQC as a way of monitoring services and any emerging risks to people using them. By failing to notify us, we were unable to take action to protect people from this suspected abuse.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2014.

Registered providers are required to display their current rating visibly and conspicuously at their premises. At the time of our inspection, the provider's rating was on display in the utility room, This room was only accessible to staff, which meant that visitors and people were unable to see the rating.

This was a breach of Regulation 20 A 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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the CQC of six significant allegations of abuse, harm and neglect. The provider was unaware they were required by law to submit these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and staff did not demonstrate an understanding of their role in regard to the Mental Capacity Act. Where people lacked capacity and decisions had been made on their behalf, the best interest decision-making process had not been followed. People's choices were restricted, such as what time they went to bed.

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 Allegations of abuse, harm and neglect had not been shared with the police, the local authority or with the Care Quality Commission. This prevented necessary action to protect people from the alleged abuse from being taken. The provider was unaware of their role and responsibilities in regard to reporting allegations of abuse and did not have an understanding of current safeguarding

processes.

People had been unlawfully deprived of their liberty due to the fact that no Deprivation of Liberty Safeguard applications had been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no system in place for capturing, receiving, investigating or responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems in place to monitor the quality of care people received. Where there were policies and procedures in place, these had not been followed. The provider was not up-to-date with key legislation underpinning their practice, such as the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient trained staff on duty to safely meet people's needs. New staff were placed on duty without a formal induction process, and without having received any training. There was no contingency plan in place to cover staff absences. Some members of staff worked 15 hours' over their contracted hours per week to ensure the shifts were covered.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service's current rating was not displayed conspicuously and visible for people and visitors. The provider was unaware this was a requirement.

The enforcement action we took:

Fixed penalty notice.