Care Quality Commission

St Mungo Community Housing Association

St Mungo's Broadway - 2 Hilldrop Road

Inspection report

St Mungo's
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15 November 2016

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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

This inspection took place on 14 and 15 November 2016 and was unannounced. When we last inspected this service in May 2014 we found two breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in medicines management and the suitability and safety of the premises. When we inspected again in September 2014, we found these areas of concern had been addressed.

St Mungo's Broadway – 2 Hilldrop Road is a care home which is registered to accommodate a maximum of 29 people with a history of alcohol misuse, homelessness and mental health conditions. On the days of our inspection, the service was providing care for 27 men.

The home had a 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.

The home was unclean. The premises and equipment within the home was not maintained. Infection control was not being followed as adequate hand washing facilities were not always available and staff did not have access to sufficient personal protective equipment (PPE) and cleaning materials.

The provider did not adequately assess risks for all people using the service. Identified risks had not been assessed for all people who used the service. Risk assessments did not provide staff with enough guidance on how to recognise risk, actions to take or how to mitigate identified risks.

There were not always enough staff deployed in the service to consistently meet people's needs. People were left on their own for long periods of time without the support of staff. Not all of the care staff on duty provided care to people. Some staff were seen to be undertaking cleaning tasks only.

Incidents and accidents were not always recorded and reported to appropriate external organisations.

The provider did not always adhere to the Mental Capacity Act 2005 (MCA). The provider did not have a MCA or Deprivation of Liberty Safeguard (DoLS) policy in place. There were no best interest decisions or mental capacity assessments highlighting that people did not have capacity to sign their care plan or forms consenting to their care. Not all staff had received training in the MCA and staff did not always understand how this legislation impacted on the lives of people they were working with.

People were not always receiving care from staff who were competent, skilled and experienced. There was a risk that people were receiving care from staff who had not received training to meet the needs of people with certain health conditions. The provider did not keep appropriate records of training, identify staff training needs or monitor when staff needed their training updated.

Not all staff had appropriate regular supervision or annual appraisals.

People did not have access to drinking water and had to ask staff for drinks which sometimes resulted in a lengthy wait and placed people at risk of dehydration.

People's privacy and dignity was not always respected.

Care plans were not person centred and did not state people's individual preferences. Most care plans had not been signed. Updated care plans were contained electronically which meant that not all staff had access to the most up to date version as some staff did not have access to the electronic care management system. Care plans were not updated to reflect people's changing health needs and important medical information was missing.

The provider did not always ensure robust recruitment practices were in place. Not all staff had a criminal records check carried out before working with people.

There were not effective systems in place to assess and monitor the quality of the service. Although some quality checking had been undertaken these had not been used to improve the quality of care for people. Records were not always completed or accurate. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had not informed CQC of all significant events in this regard.

There was an activities programme which was well received by people who used the service. However, at times we observed people sitting for long periods of time watching television without any meaningful engagement from staff.

Referrals had been made to other healthcare professionals to ensure people's health was maintained.

Staff and resident meetings were held regularly.

Medicines were managed safely and effectively.

Overall, we found significant shortfalls in the care provided to people. We identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of Care Quality Commission (Registration) Regulations 2009. As a result, we imposed conditions on the providers registration on 4 January 2017 requiring the provider complete a monthly audit of the service focusing on cleaning and maintenance, infection prevention and control, health and safety checks of the premises, staffing levels and deployment of care staff, staff training, supervisions and annual appraisals, incident reporting and staff recruitment. We also imposed a condition on the provider to submit a monthly report to the Care Quality Commission outlining the outcomes of the monthly audit and any actions taken or planned to be taken as a result.

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 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 and if 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. There were not enough staff deployed at the service to meet people's needs.

People were not always safe because risks of harm had not always been assessed and managed. Incidents had not always been recorded and reported to the appropriate authority.

Infection control measures were not in place.

The service was unclean and in a poor state of repair. People were not always protected from environmental risks.

Safe recruitment practices were not always followed.

Staff were knowledgeable around safeguarding and whistleblowing.

Medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective. Not all staff received regular, effective supervisions and appraisals. Staff were not adequately supported to carry out their role.

Staff training was inconsistent as some staff had not received recent mandatory training.

People did not always have enough to drink.

Not all people consented to their care. Care plans were not always signed. Capacity assessments or best interest decisions were not carried out where people lacked capacity. The provider did not have a MCA or DoLS policy in place.

People were supported to access healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring. Some people spoke positively

about staff and the care they received. However, other people told us that staff were uncaring and that they did not receive appropriate care.

Care plans and risk assessments were not person centred. People's likes, dislikes and preferences had not always been taken into consideration. Care plans and risk assessments contained insensitive language and terminology.

People's privacy and dignity was not always respected. However, we observed some kind and caring interactions between staff and people who used the service.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's needs were not always assessed on a continuous basis and care plans were not updated to reflect changes. Detailed information regarding people's treatment, care and support was not always recorded.

There was an engaging activities programme in place which was well received by people who used the service. However, outside of organised activities, people did not have access to meaningful activities or staff engagement.

A system for complaints was in place and displayed for people to access. However, the contact details of the provider was incorrect. People told us they could complain and relatives told us they had the relevant contact details.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have adequate systems in place to regularly assess and monitor the quality of the service.

There was a lack of senior management oversight of the service at provider level.

We could not effectively monitor what was happening in the service as notifications were not always sent to the CQC.

We observed poor staff morale and some staff told us they were not supported. We received mixed comments from people and

staff regarding the management of the service.

Staff meetings took place on a regular basis.

Care Quality Commission

St Mungo's Broadway - 2 Hilldrop Road

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.

This inspection took place on 14 and 15 November 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we already held about the service which included statutory notifications. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke to 10 people who used the service, four relatives, two senior care workers, five care workers, an activities co-ordinator, the cook, the cleaner, the deputy manager, the registered manager and the area director. We also spoke with a pest controller and external cleaner. After the inspection we spoke with one healthcare professional.

We looked at seven peoples care plans and risk assessments, daily recording notes, six staff files and records related to the management of the service.

Inadequate

Is the service safe?

Our findings

Care and treatment was not always being provided in a safe way. Risks were not being identified or where identified had not been mitigated. Risk assessments were available within peoples care files. However, care plans did not contain detailed information about actions required in order to provide safe care. Not all risks posed to people were included in people's risk assessments. Triggers and consequences were not described for all identified risks and were not entered in the risk assessment. This meant that staff were unaware from the risk assessment what could trigger certain behaviours and the consequences of the risk not being appropriately managed.

Risk assessments were updated by the person's keyworker. However, we found that risk assessment updates contained identical information as stated in the person's original risk assessment that had been completed some months prior. Important updated information was also not consistently included. Risks to people which were not assessed included; significant forensic history, health conditions such as diabetes and associated complications, epilepsy, respiratory conditions and mental health conditions.

Another person's risk assessment advised under the 'action' section, "Staff are all aware of [person's] diagnosis and the ways to prevent it from being transmitted." This record did not provide sufficient guidance to staff, which included locum and agency staff, so that they were aware of how to mitigate the risk associated with this person's diagnosis and care. A third person's risk assessment stated that staff should be 'more assertive' with a person when they became verbally abusive. The risk assessment did not detail how staff should work with the person to mitigate the risk. There was also no guidance for staff or an explanation on what was meant by 'more assertive.'

Risk assessments were completed on the provider's online system. However, the most recent version of the risk assessment was not always printed and placed in the person's file. Not all staff had access to the provider's online system. Therefore, some care staff, locum carers and agency carers did not have access to the most up to date version of the person's risk assessment.

Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications. This placed people at risk of harm as risk assessments failed to provide enough information for staff to adequately understand or mitigate risks posed to people they cared for.

An electrical installation inspection was completed by an external company in April 2015. It was found that the electrical installations at the service were unsatisfactory. There were a number of electrical defects identified as "C2" which meant that the relevant electrical installations were potentially dangerous with urgent remedial action required. We asked the registered manager if the remedial work had been carried out. He told us, "I don't remember." Following the inspection, the registered manager informed us that the remedial works had been subsequently booked. However, for a period of 19 months the urgent remedial action had not been carried out which meant that people were placed at risk of harm.

A daily health and safety check list was completed by staff. Areas checked included fire alarms, exits and doors, repairs required and lighting. Staff were using the form to highlight areas where light bulbs needed replacing. We identified that one particular light bulb situated on the first floor, outside the library and above the stairs was first noted to need replacing in April 2016. Nearly every day since then the light bulb was reported by staff to require replacing. On the second day of the inspection, we showed the registered manager the light bulb which had not been replaced. This meant that there was little oversight of the daily health and safety checks that were carried out and urgent maintenance issues that were identified were not appropriately rectified. This meant that people were placed at risk of harm as a result. A member of staff told us, "We report to the managers that things are broken, toilets are blocked. They do nothing. Sinks are blocked, we cannot clean. There are infection control problems. They don't listen. There are no strategies to help us manage the job."

On the first day of the inspection at 10:45am, the inspection team accompanied by the registered manager commenced a tour of the home. We looked at bathrooms, toilets and some bedrooms. We found toilets and bathrooms to be extremely unclean and in poor repair. Toilets and surrounding areas such as walls, floors and bath panels were dirty with faecal matter and other body fluids. One toilet in particular contained a significant level of lime scale and some toilet seats were broken. Floors were dirty and sticky. The light cords in the bathrooms were also very dirty. Toilet brushes were in a poor state of repair and some had been used as ashtrays. Toilets and bathrooms did not contain any hand washing facilities such as hand soap and hand drying equipment. The soap dispensers were empty and the hand dryers had been disconnected. We asked staff and the management team about this. Staff told us that the management team had decided to stop the use of hand soap dispensers to cut costs. A member of staff told us, "I have mentioned it to the manager. Some residents come to us to ask about hand wash. The manager said they will procure hand wash dispenser in the toilet. We mentioned it one or two times." A relative told us, "The toilets are not very clean. The floor has urine stains. Every time I go there I have to go to the toilet." The lack of hand washing facilities placed people at risk of cross-infection.

Staff were unable to access cleaning materials and personal protective equipment (PPE) as and when needed as cleaning materials had been locked in cupboards which only the registered manager and deputy manager had access to. Staff told us that they had to ask for cleaning products and PPE, such as gloves when they needed. We observed staff asking for cleaning materials during the inspection. We asked staff and the management team how staff could access cleaning products and PPE at times when the management team were not around. The deputy manager told us, "Cleaning products were going quickly. Because of that, cleaning products are locked away. We make sure there is a sufficient amount." We asked the deputy manager about when they are not at the service, the deputy manager replied, "They go to petty cash. It is the responsibility of the care staff to come to us." This meant that staff had to leave the service, whilst on shift, to purchase PPE or cleaning products. On the night of 14 November, staff told us that they had been left an allocation of 10 pairs of gloves which had run out during the night. On the morning of day two of the inspection we observed a staff member approach the deputy manager for gloves on her arrival.

Staff told us that at nights and weekends when the management team were not around, they sometimes encountered problems in obtaining cleaning equipment and PPE. A staff member told us, "A lot of the cleaning materials are locked in the manager's office. This has caused problems. We needed gloves and have run out of cleaning materials occasionally. The managers would mostly remember to leave it out." A second staff member told us, "We have no cleaning detergent. We don't even have resources. One day I washed a resident with dish washing liquid in the bath." A third staff member told us, "Personal care is really poor. We don't have adequate PPE. We always run out of aprons and gloves. The managers are not giving us the necessary equipment to clean. Some of our residents are doubly incontinent. I work weekends and I get to work and a resident has had an accident and there is faeces on the floor. There is no proper cleaning

materials in place. All the managers discuss is cutting costs."

Accidents and incidents were not always recorded or reported to the appropriate authorities. We checked the incident folder and found it contained completed incidents forms. However, during and after the inspection we became aware of a number of other incidents which had not been reported as an incident. One incident was whereby an unknown person gained entry to the service and remained there for a number of hours before being discovered by staff and asked to leave. We discussed this with the registered manager who told us, "It rings a bell." The registered manager then confirmed that this incident was not reported internally as an incident, nor was it reported to the police or the local authority safeguarding team.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition to the cleanliness concerns we identified in the bathrooms and toilets, we also identified significant cleaning and maintenance concerns in bedrooms, the kitchen, the lounge and corridors.

The kitchen area was not clean and presented a risk to people. The cooker, industrial dishwasher and deep fat fryer was dirty and in need of a deep clean. The deep fat fryer contained dirty cooking oil which was subsequently emptied on day two of the inspection. On day one of the inspection, we observed the fridge which stored food, including raw meat and dairy products at 17 degrees. Food should not be stored in a fridge at temperatures above eight degrees and ideally below five degrees. We observed that the fridge door had not been closed properly. A second fridge was broken and a new fridge had been delivered awaiting installation which had been actioned on day two. The fridge which was used to store food contained leaking milk, gone-off cream and cooked ham had been placed on top of raw meat. Salad and prepared vegetables had been left out on top of counters beside cleaning chemicals in the warm kitchen. The freezer was storing food items at minus 10 degrees and this was observed throughout both days of the inspection. The cook told us that the freezer was broken and the bottom two shelves did not work, however, food was still being stored in the freezer. Freezers should operate at a temperature of below minus 18 degrees. We reported our concerns to the local authority Environmental Health Department.

Bedrooms were unclean, with furniture in a poor state of repair. Some bedframes were loose and therefore not sturdy and mattresses and bedding contained cigarette burns. One member of staff told us, "The clients have broken wardrobes. What they sleep on, the bedding. It's so bad." Floors were sticky and contained dried in spillages. Walls were nicotine stained and showed evidence of moisture dripping. In one vacant bedroom, the sink was cracked and the wooden area surrounding the sink was mouldy and moisture damaged. The Velux windows appeared damp and had begun to rot. In another bedroom, furniture was broken and the plaster on the wall had been chipped away. The walls were stained with spillages. Curtains were poorly hung and stained. In another person's bedroom, we saw boxes of incontinence pads stacked against the wall and the boxes at the bottom were damp. The registered manager told us that there were no alternative storage places available to store incontinence pads. On day one of the inspection, we became aware that there were issues with the management of bedbugs at the home as we observed a pest controller visit and assess the affected bedrooms. However, this was not brought to the attention of the inspection team by the registered manager beforehand.

In the communal lounge area on the first floor, chairs and sofas were sticky and contained dried in spillages which had not been cleaned. We pulled furniture away from walls and found significant amounts of food matter. A plastic plant was littered with cigarette butts. In the dining area, the wall around the food service hatch was stained with food spillages. The floors on the corridors were sticky and we saw ingrained dirt around skirting boards and door frames. On the second day of the inspection, the area director was

available at the home and we showed him our findings. Some initial remedial cleaning and descaling of toilets by an external cleaning service took place on day two of the inspection.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff employed and deployed to meet people's needs. At the time of the inspection, there were 27 people using the service. We discussed staffing levels with the registered manager and deputy manager. When asked if staff levels were sufficient, the deputy manager told us, "No, it's not commensurate with the size of the project and complexity of the clients." We were informed and rota's confirmed that there was one senior social care worker and two care assistants on duty from 8:00am until 11:00pm. The day was split over two shifts; 8:00am until 4:30pm and 2:30pm until 11:00pm. At night there was one carer on duty with one sleep in carer to assist if necessary. The senior carer for the most part remained in the office and administered medicines, allocated budget allowances to people, updated electronic records and monitored closed circuit television CCTV. The senior carers were also keyworkers to approximately 10 people each. There was one cleaner on duty from Monday to Friday to clean communal areas and bathrooms only. On Mondays there was a janitor on duty who assisted with cleaning in addition to minor maintenance tasks. At weekends, there was a locum cleaner present on Saturdays and no specific cleaning provision on Sundays.

Cleaning bedrooms was the responsibility of the care assistants and on Sundays care assistants were also tasked with cleaning communal areas in addition to bedrooms. Cleaning bedrooms was on a scheduled basis with some bedrooms requiring a daily clean, some twice weekly cleans and some bedrooms were cleaned once per week. Staff told us that it was a struggle for them to ensure bedrooms were properly cleaned as they had other care responsibilities which included assisting people with personal care, accompanying people to appointments, supervising mealtimes and assisting people with showers and baths at weekends. One member of staff told us, "One cleaner works Monday to Friday. Especially on Monday, it's filthy. We are supposed to clean. Sometimes you walk over faeces. We are so out of touch. We run around and the clients are left on their own. Sometimes they stand in the office with urine dripping down their legs." Another member of staff told us, "There is only one cleaner and over the weekend it's so dirty. The residents [urinate]. We carers always struggle to keep [the home] clean."

We observed that aside from supervising meal times, the communal areas were generally left unsupervised and we observed little interactions between people and care staff in those areas. One person told us, "I find it very hard if I need something. Sometimes the office is closed and I have to wait for a long time. The staff are not available and it's very frustrating." Another person told us, "Sometimes it's very slow to get things done by staff." A staff member told us, "We said there should be a safe place for residents to get tea and coffee and juice, but no. They [people] couldn't get anything. It can take up to an hour, if they're lucky to get a cup of tea or coffee. Two staff upstairs cleaning and one in the office." This meant that staff were not readily available to provide people with assistance when needed.

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

For most staff, the service had applied for a criminal records check on appointment to the post. Recruitment records were kept at head office and during the inspection we requested pre-employment checks for six staff members. One week after the inspection, we received confirmation that out of the six files we requested, one care assistant, employed in this role since April 2016 had not had a criminal records check (DBS) completed. On receipt of this information, we requested confirmation that all staff employed at the service had undergone a DBS check. We subsequently received confirmation that another care assistant,

employed for a number of years also had not had a DBS check completed. The provider told us that they would ensure both staff members would be supervised until receipt of a satisfactory DBS check. In addition, we also saw evidence that the provider did not appropriately follow up or risk assess when a DBS contained significant information. These staff had been working with vulnerable adults without appropriate checks completed by the service. The service did not ensure that appropriate checks were carried out and documented for all staff that they employed.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were being managed in a safe way. A relative told us, "They are really good with making sure medicines are reviewed. If [my relative] has a wobble, they call the GP." There were no gaps in the medicine administration records (MAR) showing people had received their medicines as prescribed. MAR charts contained a photo of the person. People who self-medicated were checked on twice per week to ensure that they were safely managing their own medicines. A daily check was completed by either the registered manager, deputy manager or a senior carer to confirm that medicines had been administered as prescribed and signed for. There were records for 'as needed' medicines (PRN). These are medicines that are prescribed to people and given when required. A PRN medicines protocol was also contained within the medicines folder and we saw that where PRN medicines had been administered, it was on an occasional basis. Medicines requiring refrigeration were stored in a fridge. The temperature of the fridge was monitored daily to ensure the safety of medicines. At the time of the inspection, nobody was taking controlled medicines. Controlled drugs are medicines that the law requires are stored, administered and disposed or following the Misuse of Drugs Act 1971.

When asked if they felt safe at the home, we received mixed comments from people. One person told us, "Yes, feel safe." Another person told us, "I would change nothing. I am very happy with the service. The staff are good and helpful." Another person told us, "If I could change anything. I would close this place. People are treated like criminals. They don't help me." A relative told us, "I know they look after [my relative] and he is safe."

The provider had a safeguarding policy in place and staff demonstrated knowledge of safeguarding. However, training records supplied to the inspection team following the inspection confirmed that not all staff had had received safeguarding training. One member of staff told us, "Safeguarding means looking out for different types of abuse; physical, mental, financial, emotional. We are very much on the ball and we report to the manager." Another staff member told us, "Relates to vulnerable people. It's about abuse. Physical, financial, all sorts of abuses people can be subject to. If I saw it I would bring it up straight away or I would go to [the] area manager, local council, Care Quality Commission." Staff were knowledgeable around recent safeguarding matters and outcomes from investigations as this was discussed in a staff meeting and when asked, staff told us of the outcomes and actions required by the service. Easy to read safeguarding information was displayed in the library for people to refer to. However, the provider had not informed the Care Quality Commission of all safeguarding matters. There is more detail about this in the well led section of the report.

The provider had a whistleblowing policy in place and staff were knowledgeable about what whistleblowing meant. One member of staff told us, "Every day we communicate and they [management] respond. If they don't respond I know what to do. I challenge bad practice."

Inadequate

Is the service effective?

Our findings

Relatives told us that they felt staff were appropriately trained. One relative told us, "We are very happy with them. [Our relative] is looked after well there."

When asked about food, a relative told us, "[My relative] would say food is not up to standard. They do give loads of options." We received mixed comments from people regarding food and the choices on offer. One person told us, "Food is good. I wouldn't change anything." Another person told us, "There is no water to drink. You are left to die."

People using the service had the option of a cooked breakfast in the morning or porridge. At lunch, people were offered the choice of a meat option or a vegetarian option and in the evening people were offered sandwiches. The provider employed the services of a catering company to prepare meals. Menus were not displayed in the dining area. Menus were planned on a monthly basis. A member of staff told us, "Part of the problem is the kitchen is forgotten. They don't have menus and they don't have choice. There is a board on the left by the door. Five out of ten times the food prepared is not what is on the board. Sometimes the cook asks staff what am I supposed to do. There is no pasta or rice." We observed mealtimes at the service. The registered manager supervised breakfast time. This was to ensure that tension did not arise between some people. Care staff monitored lunchtime. We noted that care staff also ate their meals at the same time as the people using the service. However, we observed that care staff sat at a separate table away from the people using the service and there was minimal engagement between care staff and the people using the service.

Snacks were not available to people outside of the main mealtimes and people did not have access to a kitchen or a suitable facility to prepare their own snacks or hot drinks should they have chosen to do so. We observed that some people had a kettle in their bedroom. In one bedroom we saw that the person did not have suitable storage for milk which had been left out and curdled. People who did not have kettles in their bedrooms, had to ask staff whenever they wanted a hot drink. A member of staff told us, "They love their hot drinks. Some have kettles." We asked staff about this and one member of staff told us, "There used to be a tea dispenser here. It has been discussed before. The general consensus is it could be smashed up. Water at the moment is supplied through jugs." When asked about people having to request drinks from staff, another member of staff told us, "It's part of them coming to us and we see them. If the day goes and we don't see them, we presume they are sick." We observed that at breakfast time, people came in with their own cups and made a cup of tea as there were teapots containing hot water sitting out. We observed that people's cups were quite dirty. People were physically capable of making their own hot drinks. The provider had not worked in a way that enabled people, who could make their own hot drinks, to do so in a safe way. One evening we observed a person sitting outside the office. He told us he was waiting for staff to make him a hot drink. He told us that he could make his own hot drink if he was supported to do so.

We observed that people did not always have access to drinking water. Drinking water was supplied to people using the service via a water dispenser with large water containers. The registered manager told us that a few months prior (July/August 2016), there was a payment dispute between the provider and the water supplier and the water delivery was stopped. We observed empty water containers sitting on the floor

around the water dispenser. We discussed this with the registered manager and deputy manager who told us that jugs of water were made available to people. However, we observed that jugs of drinking water were not always made available to people. People had to ask staff for drinks of water which resulted in at times a lengthy wait if staff were engaged in other activities. This placed people at risk of dehydration. On one occasion, a member of the inspection team intervened and asked a member of staff for a jug of water and cups for the residents they were talking with. It took 30 minutes for the staff member to provide the water and cups. Following the inspection, we received confirmation that the area director intervened and drinking water was delivered to the home.

We identified that one person using the service had a particular diagnosis. Their care file contained guidance regarding minimum fluid intake guidelines for people with this diagnosis. However, their care plan was not updated to reflect this information, nor was their fluid intake monitored. This person also had no access to drinking water as the taps in their bedroom had been removed. Therefore this person relied on asking staff for drinks. This meant that this person was at risk of dehydration as their fluid intake was not being monitored.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed responses from staff in relation to training and supervisions. Most staff felt the training they received was adequate for their role in order to meet people's needs. Some staff we spoke to told us they had regular supervisions and appraisals. One staff member told us, "Trainings regarding MCA, health and safety, moving and handling every two to three years, inclusiveness and diversity at work. St Mungo's and managers tell us to go on the website to tell them if there are training." Another staff member told us, "We need more effort and more training." Another staff member told us, "We recently did MCA and dementia training online." However training records made available to the inspection team did not reflect staff comments.

Staff training records for 13 permanent members of staff were supplied to the inspection team after the inspection. Training records showed that five staff members had no documented safeguarding training; seven staff members last received safeguarding training in 2010 and 2012. The providers safeguarding policy for adults stated that safeguarding training should be renewed every three years. Training records showed that the registered manager last received medicines training in 2003, the deputy manager last received medicines training in 2010, one senior care assistant had not completed medicines training and two senior care assistants had last attended medicines training in 2010 and 2012. Training records showed inconsistencies in training staff received in areas such as mental health awareness, first aid and training around the Mental Capacity Act 2005. Staff had also not received training around supporting people living with dementia. One member of staff who commenced employment as a care assistant in 2016, having previously worked at the service in a different capacity had no induction or training recorded since commencing their current role and the last recorded training they had received was in 2014. This lack of training affected staff skills experience and may have prevented staff from supporting people effectively.

Staff supervisions and appraisals were also inconsistent; with some staff having received regular documented supervisions and appraisals and other staff not. The registered manager and deputy manager line managed different staff. A staff member told us, "I don't get my supervision notes of supervisions. I've had one supervision in two years." This meant that not all staff were not being adequately supported to carry out their role.

This was a breach of regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations

2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for 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 lacked 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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. A DoLS was in place for one person using the service. People could leave the service freely as there was no restrictions on the front door.

The provider did not have a MCA or DoLS policy in place. The deputy manager gave us a print out of the online resources the provider had for staff dealing with MCA related issues and guidance for DoLS. This service provided care for a number of people living with either the early stages of dementia or diagnosed dementia which was advancing and whereby their mental capacity may change. This meant that the provider was not providing specific guidance to staff and managers who may have had concerns around mental capacity or DoLS related issues. As updated care plans and risk assessments were not always printed off following a review, we could not be satisfied if the person who used the service had been involved or consented to their plan of care. Where care plans in files were available and not signed, the care plan did not contain details as to why the person receiving care had not signed their care plan. Care plans did not note whether specific decisions had to be made on behalf of people and whether this was in their best interest. A best interests decision is made on someone's behalf where they are unable to make decisions for themselves.

One person using the service was living with dementia and had been previously assessed as not having the mental capacity to make informed decisions regarding their home environment and financial decisions. However, this person had signed their care plan and risk assessment. The person's capacity had not been assessed to establish whether the person had the capacity to consent to their care.

Not all staff had received training in MCA or DoLS. Training records provided to the inspection team after the inspection showed that one staff member received MCA training in 2009. Staff knowledge of MCA and DoLS and how this affected their role was mixed. One staff member told us, "We need to be aware of what happens when we relate to residents diagnosed with mental health. How we support them on a daily basis. Resident's involvement in how to care for them. Sometimes they lack capacity." A second staff member told us, "It's about people who are vulnerable in terms of mental health. You assume capacity unless you have carried out a test. You should assume people have capacity unless you can prove they don't. You need next of kin, independent advocate as well. People have a right to decide how they want to live their life. For example, we have people who have terminal illness. We should be discussing with them what their wishes are and what they want so that it's done in case they lose capacity and we can act on their wishes." A third staff member told us, "They don't have the capacity to make decisions. Managers have to be able to work with them."

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

People were appropriately supported to access health and other services when they needed to. People's care files contained documentation of health appointments, letters from specialists and records of visits. However, following healthcare appointments, care plans were not always updated afterwards. This has been further elaborated in the responsive section of the report. A relative told us, "We talk to management on the phone. They contact us immediately with updates." Another relative told us, "They make sure [my relative] attends his appointments."

Requires Improvement

Is the service caring?

Our findings

There were instances of insensitive language in people's care plans which lacked understanding that people's behaviours may have been as a result of their health condition. One person's care plan referred to a certain behaviour as 'bad' and they were 'given a serious warning and barred from sitting in the lounge except when he comes in for meals." Their care plan further stated, "[Person] did not comply. Instead he disappeared from the project for three days and was found sleeping rough in front of [named hospital]." Another person's risk assessment referred to their mental health deteriorating and their diagnosis of dementia. Their care plan stated, "[Person] is always cleaning the floor and picking up dirt. When he is asked to stop and informed there is a cleaner in the project whose job it is to do cleaning, he gets angry and sometimes aggressive." No support measures were put in place to assist this person should they have wished to clean which may have reduced instances of aggression. Another person's risk assessment stated under 'Inappropriate behaviour,' "[Person] is an attention seeker. He likes to be seen all the time and having one thing or another to sort out and request."

We observed a handover on the morning of day two of the inspection and comments from the carer completing the handover included, "[Person] kept coming out for a cup of tea," and "[Person] was in and out of the building. I hope when I come tonight, he will be in his bed."

People's privacy and dignity was not always respected. In one person's bedroom, numerous boxes of incontinence pads were stacked against a wall in full view of the doorway of the bedroom and people and visitors passing by. The registered manager told us that incontinence pads were delivered on a six monthly basis and there was nowhere to store the boxes.

This was a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Some people spoke positively about staff. A person told us, "I am happy with the staff. Yes, I get good support." Another person told us, "It's okay. It's more relaxed. The staff are helpful to me. We are on a need to know basis but the staff do look after you." A third person told us, "I am happy with the service but other people are not." However, we received concerning feedback from some people who used the service. One person told us, "I don't like this place. You're being controlled by staff. I feel like I am being punished. It feels like an open prison." Another person told us, "I am not happy with the place. They take you for a bath and you get bad treatment. I don't like anything about this place." Relatives told us they were satisfied with the care their loved ones received. One relative told us, "We ask [my relative] questions. We ask him if he is okay. Most of the time he says he is okay. They are all really good, really attentive. They all seem to care."

We received mixed comments from staff regarding the level of care provided to people who used the service. One staff member told us, "We get to know the people. Sometimes we sit with them and in the lounge or their bedroom and have a chat. I tell them about myself, for example my football team and we start a discussion. Some of them come up with something new and we share with colleagues." Another staff member told us, "It's important to sit down with them and chat with them. When I am showering [person], I

get his life story. He wouldn't have lunch so I went out to get him a cup-a-soup. You do build a relationship. They feel like they can come to me." A third member of staff told us, "I love it. I love all the people. I love them." However, some staff raised concerns around the level of care provided. A staff member told us, "We rely on agency staff. There is no consistency in care. The residents are anxious and they don't know who is taking care of them. This place doesn't give support for people to utilise their ability and skills. The residents feel they are to blame and they say sorry." A second staff member told us, "It's not a home. There should be a difference between a home and a hostel." A third member of staff told us, "There is no quality care. There is rushed care. I don't think we are giving them quality care. Their rooms are untidy. We rush to do the dinner and lunch and there is not enough time to care."

We spoke with people and relatives about whether they felt involved with their own care provision or the care provision of their relative. A person told us, "I do feel involved in decisions about my care." A relative told us, "They need to know a lot from me. I try to attend [care reviews]. [The registered manager], he is really good. A great support."

We observed staff interaction with people who used the service and noted some instances of kind and caring interactions. We observed a member of staff being kind and caring to a person. The staff member knocked on their bedroom door and reminded them to take their medicines. The staff member reassured the person when they became confused.

However, we observed some people waiting around the office on the ground floor for assistance and we saw staff telling people to come back in 10 or 15 minutes when they approached them for a hot drink.

Staff gave us examples of how they maintained and respected people's privacy. These examples included keeping people's personal information secure as well as knocking on people's doors. A staff member told us, "I have to give medication every day. I do one resident at a time. I ask if they want to take a seat, ask what they require. Polite, encouraging [conversation]. Ask about their day, ask if they had breakfast and if they're okay. Engage in conversation." Relatives told us that when they visited the service their discussions with staff were confidential. A relative told us, "Today when we came back from the appointment we went into a room so we could talk in private."

Equality and diversity was promoted at the service. We saw cultural and religious events were celebrated. Black history month in October 2016 formed part of the resident and staff meetings. We saw that the service held a Black History celebration with activities, music and Afro-Caribbean food. Some people who used the service also engaged with Irish cultural events. Staff we spoke with understood what equality and diversity meant and how that affected the care they provided for people who use the service. When asked about supporting people who identified as lesbian, gay, transgender or bisexual (LGBT), a member of staff told us that people who identified as homosexual were supported, "It's not a problem. They are accommodated."

Requires Improvement

Is the service responsive?

Our findings

Care plans and risk assessments were not person centred. Personalised information such as people's likes, dislikes, favourite foods, family or work background and favourite activities or past-times were not detailed in their care plan. Care plans were task focused. We found that care plans were not always up to date and did not always contain accurate relevant information. Care files contained letters regarding healthcare appointments and outcomes. However, care plans were not updated afterwards to include new health conditions such as optical health and respiratory conditions.

We noted a person whose care plan said they were banned from communal areas. We brought this to the attention of area manager following the inspection who confirmed that the person was no longer barred from the communal areas. However, their care plan had not been updated to reflect this. Their care plan had referred to appointments to obtain a diagnosis for a health condition in January and February 2016, however their care plan which was updated in October 2016 did not reflect their subsequent diagnosis and how they should be supported.

Another person's care plan referred to the person being supported to attend in-house activities, however, their care plan did not state which activities they liked. Their care plan also referred to them being supported to attend healthcare appointments. However, the nature or frequency of the healthcare appointments was not elaborated on.

For all people with a diagnosed mental health condition, there was no information in either their care plans or risk assessments that detailed how the person's mental health affected them. There was also no information on what it meant for them, the last time they experienced mental ill health or how staff could work effectively to support the person with their mental health needs.

Another person's care plan referred to the involvement of a speech and language therapist (SALT), however, their care plan did not contain any information relating to the outcome of the SALT involvement or instructions on how the person was to be supported with this assessed need.

Care plan reviews contained identical information as previous care plans. We discussed this with the registered manager and deputy manager who confirmed that staff could 'clone' information from care plans on their online system. The registered and deputy manager told us this option had been removed from their system shortly before the inspection.

This was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there was a pre-assessment system in use at the service. One staff member told us, "From inception, right through, the managers make available the referrals and a copy is given to each staff. We need to go and study and read about the risk. Then we go to meetings and discuss potential people. We go through it and make our opinion known to managers. We see if that person could be handled." Staff

meetings referred to people who had been assessed as not suitable for the service and staff discussed potential people who had been referred to the service.

There was an activities programme in place at the home. A dedicated life skills worker was employed to deliver an activities programme two and a half days per week. In addition, a volunteer assisted with art activities one afternoon per week. There was also yoga on a weekly basis and massage therapy once every two weeks. Activities in the programme included regular exercise sessions, music and song writing, art, discussions about current affairs and gardening. People spoke positively about the activities programme and on the morning of the second day of the inspection, we observed people awaiting the arrival of the life skills worker. The life skills worker delivered the activities programme at the service. People invited the inspection team to join in with the activities.

We observed the activities programme on day two of the inspection and attended a session where people read newspapers and engaged in a discussion around current affairs. People were offered a hot drink and biscuits were provided. We observed people actively engaging and enjoying the session. Day trips also formed part of the activities programme. In September 2016, people attended an art workshop at the Royal Academy of Arts and in July 2016 people went on a day trip to the seaside.

The life skills worker spoke positively of the impact the activities programme had on people using the service and gave an example of where one person sold artwork at an art exhibition. The life skills worker told us that people who used the service formed part of the interview panel for potential volunteers and that she had been interviewed by people. We saw art work on display in the library and the results of people predicting the outcome of the recent US presidential elections.

Resident meetings took place with the life skills worker on a regular basis. Ideas for future activities were discussed along with any issues people had regarding their care provision. The management team did not attend the meeting and the life skills worker fed any issues back to the management team. When asked why the management team did not attend these meetings, the registered manager told us, "I don't think that they [people] would be free [to talk]."

Outside of the planned activity schedule there was little provision for activities. There was a pool table in the lounge and we saw some people playing pool in the afternoons of the inspection. We observed people sitting in the lounge passively watching television with little staff engagement aside from mealtime supervision. One person told us, "They stick us in here and just put the TV on. We need more activities. There is not much stuff for [people]. They put the BBC news channel on the TV and the same thing just goes around and around. The TV in the bedroom only has one channel." A staff member told us, "Nothing happens when [life skills worker] isn't here." Another member of staff told us, "Not much at weekends except some people go to church." We discussed the lack of evening and weekend activities and whether staff could plan activities with the registered manager and deputy manager. The deputy manager told us, "Staff would think that they wouldn't be able to do that. That innovation is not there." However staff had not been given support or guidance to use their initiative.

We checked how the service handled complaints. The complaints folder contained one complaint from June 2016 which was investigated and appropriately responded to. We saw complaint forms were available in the library for people to complete, however, the contact details for the provider on the complaints form was incorrect as they were old. One person told us, "I feel I do get listened to if I make a complaint." A relative told us, "No complaints. We have the contact details."

There were arrangements in place for people to provide feedback. A questionnaire was sent to people and

relatives on a yearly basis and the results were collected and analysed by an independent provider. The general manager told us that the feedback survey for 2016 had just been completed had not yet been collated or analysed. A relative told us, "They always ask for feedback. Is there anything we can do? Should we try this? Should we try that?"

Inadequate

Is the service well-led?

Our findings

We reviewed information we held about the service prior to the inspection and noted that aside from two police incidents in June 2016 and a death notification in May 2016, we had not received any statutory notifications from the service since November 2014. During the inspection, we became aware of a number of incidents and events which the registered manager and the registered provider were legally required to inform CQC about. Notifications that should have been completed included the death of a person using the service, a DoLS authorisation, an allegation of abuse which resulted in a police and safeguarding investigation, five police incidents and one incident of serious harm to a person using the service. This meant that the provider had not told us about significant events affecting people's care and support needs.

The failure of the registered manager and provider to inform CQC of the death of a person using the service is a breach of Regulation 16 of the CQC Registration Regulations 2009.

The failure of the registered manager and provider to notify CQC of other significant events is a breach of Regulation 18 of the CQC Registration Regulations 2009.

We received mixed comments from people regarding the management structure in place at the home. One person told us, "[The registered manager] will listen to my problems and try to support you. He's very helpful. I've got a lot of respect for him, all very good staff and [registered manager] very accommodating to me." Another person told us, "I once went and asked for some money and the boss said I'm entitled to nothing. Nothing gets done. It's like talking to the wall." A relative told us, "I talk to one of the staff in charge. I don't know her name but she is very nice." Another relative told us, "I have had no dealings with [the registered manager]. My only criticism is at weekends. There doesn't seem to be anyone to inspire me with confidence or take ownership. Staff don't really know anything." A healthcare professional told us that the service got in touch with them promptly, there was an open and good culture and the service worked really well.

We received varied comments from staff regarding the support they received from the management team. A staff member told us, "They support us. They tell us what help we can get if we come to them. In terms of the pressure from the job, we talk to them. We get good feedback and get good advice." A second staff member told us, "It's well managed. Very well managed. The deputy manager is very experienced. [The registered manager] is very supportive. If we slip up, we are told." A third member of staff told us, "All staff should be equal. They tend to listen to some and not others for us all to carry out our jobs effectively. We report things and no actions are taken. There is no support for staff. It is really difficult." A fourth staff member told us, "They are trying to put the blame on staff, that we are not doing enough. They haven't provided support." A fifth staff member told us, "Management does not order stuff, it's about money. In the cleaning cupboard we have no hand soap. We have to go to the shop to get washing powder. Everything is locked. We have to manage the gloves; they are kept in the office. There are some in the cupboard in the small office but we have to wait for management to let us get them. What are we supposed to do? Give personal care with no gloves?"

Comments received from staff we spoke to reflected a blame culture at the home, where care staff were blamed for poor standards of care. We also noted this from our conversations with the management team during the inspection. Poor staff morale was evident from our discussions with staff during and after the inspection. A staff member told us, "Sometime they forget on a Friday to give us cleaning stuff and we have nothing. Then they say why didn't you ask? It's a huge blame culture."

Staff also raised concerns regarding senior managerial oversight at the service. One staff member said, "To be honest. I can summarise this place in one word, forgotten. When you look at the bigger picture, the surroundings, the home, the building, the residents and staff." Another member of staff told us, "It's really difficult. Some of them [staff] have been groomed into bad practice. Honestly, I think the senior managers have forgotten Hilldrop Road. This should have been picked up."

The service's quality assurance system was not effective. Care plans and risk assessments were not person centred, lacked important information and contained insensitive terminology and language. Care plan reviews were ineffective as updates and changes were not included. Risk assessments were not detailed and identified risks had not been assessed and guidance was not included to support staff to mitigate the risk. The provider failed to ensure that up to date care plans and risk assessments were available to all care staff working with people.

There was no system in place to monitor how the Mental Capacity Act 2005 (MCA) was applied when obtaining consent from people prior to care being provided.

Staff did not receive regular effective supervisions and appraisals. Staff training was inconsistent and records were not kept up to date.

Recruitment systems in place were not robust and deficiencies in the recruitment process had been identified by the inspection team. It was noted that some of the recruitment process was completed by a central recruitment team.

Health and safety checks did not have managerial oversight. The registered manager did not ensure that basic standards of cleanliness, hygiene and maintenance were maintained. An unsatisfactory electrical installation inspection was not promptly addressed.

Incidents were not always reported and escalated to the appropriate external organisations, such as CQC or the local authority.

People did not have access to sufficient drinking water for a number of months prior to the inspection and interim measures in place had not been effectively monitored by the management team.

A health and safety check was undertaken by an external provider in June 2016 which identified some areas which needed addressing. The registered manager and deputy manager completed an action plan and addressed some of the areas for improvement.

The registered manager told us it was the responsibility of the area manager to conduct a quality audit of the home. However, at the time of the inspection, this had not yet been completed.

When asked by the inspection team how the service was being monitored, the registered manager told us, "I check care plans quarterly with key workers. I check training. I supervise breakfasts in the mornings. I ensure appointments are checked. I check the room cleaning rota. I check food. I check finances. I check activities. I

provide funds for daytrips." The registered manager told us that there were no unannounced spot checks. However, he reviewed the CCTV every morning which resulted in one staff member being dismissed for sleeping on duty. However these checks completed by the registered manager did not identify the concerning issues we found during the inspection.

Overall, we found a lack of managerial oversight in relation to care planning, risk assessments, compliance with MCA, cleanliness and maintenance, access to hydration, incident reporting, staff training, staff supervisions and appraisals and aspects of staff recruitment.

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

Following the inspection, we communicated the significant concerns we found at the service to the provider's senior management. At our request, the provider supplied an urgent action plan to demonstrate to CQC that they would take the necessary urgent actions to address the serious concerns we identified.

Daily handovers took place twice a day. The night staff handed over to the day staff and the day staff handed over to the evening staff. Staff discussed people's upcoming appointments for the day and confirmed that particularly vulnerable people had been seen and were okay.

Staff confirmed they attended regular staff meetings and most staff told us they felt able to raise any issues or concerns. We looked at staff meeting minutes from the past three months and saw that vulnerable clients were discussed and updates were provided to staff. Minutes showed that staff raised concerns they had around food, cleanliness, workload and vulnerable residents. One staff member told us, "We all participate very well in meetings. We discuss vulnerable residents." However, another staff member told us, "Staff tear each other to pieces and [the registered manager] does not say anything. Once a month (staff meetings). It's the first Wednesday of the month. It's not worth it as I get so upset."

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 16 Registration Regulations 2009 Notification of death of a person who uses services The registered manager did not inform CQC of the death of service User.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager did not inform CQC of other notifiable incidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10(1) The provider did not ensure all service users were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) Care and treatment was not always provided with the consent of the relevant person as the registered provider was not always acting in accordance with the Mental Capacity Act 2005. The provider did not have a MCA or DoLS policy in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14(1) The provider did not ensure that water was available and accessible to service users at all times.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1)(a)(b) The provider did not ensure care plans contained accurate and up to date medical information for all people who used the service. The provider did not ensure care plans were person centred.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 4 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. The provider did not ensure the premises used by the service provider is safe for their intended purpose and used in a safe way. The provider failed to assess the risk of, and preventing, detecting and controlling the spread of infections.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 4 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15(1)

	The provider failed to ensure that all premises and equipment was clean and failed to maintain standards of hygiene appropriate for the purposes for which they are being used.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 4 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) The service did not have effective systems in place to record and monitor the quality and safety of service provision in order to improve, learn and develop.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 4 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19(1) The registered provider did not ensure a robust recruitment procedure by ensuring staff employed were of good character and had the skills and experience which were necessary for the work to be performed by them.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 4 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The provider did not ensure there were sufficient levels of staff were suitable deployed to ensure all other regulatory requirements were met. The provider did not ensure all staff received support, training, professional development, supervision and appraisals.

The enforcement action we took:

We issued a Notice of Decision imposing conditions on the provider on 4 January 2017.