Orchard Care Homes.com (5) Limited

Norton Lees Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection took place on 17 October 2016. The home was last inspected in January 2014 and was found to be fully compliant at that time.

Norton Lees Hall is a 40 bedded care home which offers accommodation over two floors for older people and people living with dementia. The home is run by Orchard Care Homes Ltd. It is located in the Norton Lees area of Sheffield close to local amenities and local transport links.

There was no registered manager in place at the time of the inspection; however there was a manager in place who was planning to register to manage the service. 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.

Staff had undertaken safeguarding training and were able to demonstrate their knowledge and understanding of how to protect people from harm.

There were risk assessments in place which related to all aspects of people's needs; however some of these did not identify specific risks and show the measures needed to minimise the risks.

There was sufficient staff to meet people's needs, other than at lunchtime on the first floor, where there were people who had to wait a significant time for assistance. People had access to a choice of food and drink throughout the day.

The management of medicines was safe and records were well-maintained.

The home was not clean in some areas and there were malodours present in some places.

Staff received all mandatory training and this was regularly refreshed. Staff received supervisions and appraisals.

Mental capacity assessments were not completed correctly and were contradictory to other information about people, which included the applications made for Deprivation of Liberty Safeguards.

Staff were kind, caring and patient and have positive relationships with the people they supported.

People's dignity was not always protected as people were not asked if they wished to be assisted to the toilet, and people were not always given their own clothes to wear.

Care plans were detailed and person centred, and regularly reviewed, however there was no evidence people were involved in the creation and review of their care plans.

There was a programme of varied activities which we observed people to enjoy, however some people were at risk of social isolation as they remained in their rooms.

Staff felt supported by the management team; however feedback from relatives was that there had been a lack of consistent management in the home for a long period.

Monitoring processes whilst extensive were not consistently carried out and were not effective in identifying issues and ensuring action was taken to achieve the necessary improvement.

Records were not always of an acceptable standard as they lacked detail and did not achieve their purpose because of this.

The provider was not meeting the requirements of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

There was usually sufficient staff on duty to meet people's needs.

Some areas of the home were not clean.

Staff had undertaken safeguarding training and were able to demonstrate their knowledge and understanding of how to keep people safe from harm.

There were processes in place for the safe management of medicines which meant people received their medicines as they were prescribed.

There were risk assessments in place, however these did not always identify specific risks and the measures to minimise them.

Is the service effective?

Requires Improvement

The service was not always effective

There were some mental capacity assessments; however these were not adequately or correctly completed. There had been a large number of Deprivation of Liberty Safeguard (DoLS) applications made over a long period, however there were none which had been authorised.

Food and drink was available to people throughout the day, however the intake of food and fluid was not well monitored where people had weight loss or were unwell.

Staff had undertaken training and this was refreshed regularly.

Is the service caring?

Requires Improvement

The service was not always caring

We observed staff did not always maintain the dignity of people; this was in relation to people being offered support to use the toilet, and clothes being given to and worn by people to whom

they did not belong.

We did not see any evidence that people had advocates in place where they did not have a relative or friend to support them to make decisions and make their wishes known.

Staff were kind, caring and patient when assisting people in the home, and there were positive relationships evident.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found there had been no complaints recorded since February 2015; however people we spoke with told us they had complained since this time.

The care plans were detailed and referenced people's wishes and preferences. There were life histories included which allowed care staff to understand people's backgrounds. Care plans were regularly reviewed.

There was a programme of activities advertised in the home and we saw these activities taking place and people engaging with the activities coordinator.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff morale was good; however there had been recent changes to the management of the home which were still being embedded.

Whilst there were processes in place to monitor the quality and safety of the service, these were not consistently carried out and there was little evidence of analysis and actions being identified and completed to achieve improvement.

The records which were kept to show the care people received each day were not detailed and did not fulfil their purpose.

Norton Lees Hall

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 17 October 2016 and was unannounced.

The inspection was carried out by two adult social care 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 care service. The expert by experience had knowledge of the care of older people and people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the home which included statutory notifications of notifiable events. A notification is the action that a registered provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We sought feedback from the local authority which commissions services from the home.

During the inspection we spoke with six people who lived at the home, four relatives who were visiting, a district nurse, six members of staff, the manager, the care manager and a senior carer. We observed interactions between staff and people in the home throughout the day, including during activities and at lunch time.

We reviewed the care records of four people, three staff recruitment and training files, medication records and records which related to the processes in the home and the monitoring of the quality and safety of the care being delivered.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with said they felt safe at Norton Lees Hall and relatives we spoke with told us they felt their relatives were safe in the home.

Staff we spoke with told us they had undertaken safeguarding adults training and were able to demonstrate their knowledge of the types of abuse, and the processes they would follow if they were concerned there may be abuse taking place. Four relatives we spoke with told us they had requested their relative's rooms be kept locked as people were wandering in and out of them and they were concerned things may go missing as a result.

We found there were risk assessments contained within people's care files, these included various aspects of people's needs, for example, the use of equipment to assist people who could not move independently, the use of bed rails and skin integrity. We found that whilst the risk assessments were in place and correctly filled out in most cases there were some in relation to specific tasks, which did not always record specific identified risk or show the measures which needed to be in place to minimise the risk. For example, bed rails assessments did not include the risk of entrapment or injury.

We also found that where it was necessary to monitor any aspect of a person's care, for instance where a person had lost weight and needed their food and fluid intake to be monitored the information was not detailed and would not allow a health professional to gain any insight. We discussed this with the manager who showed us a new form which was being implemented immediately to ensure the correct level of detail was recorded.

We reviewed the records in relation to the safety and maintenance of the home. We found all the mandatory safety checks had been carried out and the certificates were in date, this included legionella safety, gas and electrical appliances and the maintenance of the lift and equipment used to assist people who are unable to move themselves independently. We found and people all told us the temperature on the first floor was uncomfortably hot at times. Staff confirmed this was the case and that it was unpleasant to work there at times because of this. A relative told us it had been reported at the relative's meetings and the managers had reported it to head office but nothing has ever been done. They told us "It hasn't been too bad this summer, but on occasion it has been very hot and you can't open windows for safety reasons." The manager told us they had tried to use portable air conditioning units, but this had proved ineffective. There were no further plans in place to rectify the situation

We examined the personal emergency evacuation plans (PEEPs) which were in place. These were completed on a traffic light basis with people being assessed as red, amber and green depending on their level of dependence. The plans which corresponded with the assessments, however, were not detailed enough to ensure the safe evacuation of all people in an emergency, as there was no instruction to staff on how to assist people who had a disability to get to the ground floor from the first floor. We discussed this with the manager who told us as there was an adjoined building they could move people via connecting doors to the

other building to keep them safe; however they agreed they would add the detail we requested to the PEEPs.

We reviewed the records which were kept in relation to accidents and incidents which took place in the home. We found there were individual records kept of each event and these were logged onto a monthly summary sheet. We saw there had been falls analysis carried out for June and July 2016, but this had not happened in August and September 2016. We discussed this with the manager who told us this was because they had changed the system they were using and this would be completed in the future.

We observed the number of staff who were on duty and reviewed staff rotas to clarify how many staff were on duty during each day. We found there were sufficient staff on duty most of the time; however there was insufficient staff to support people at lunch time on the first floor. This resulted in some people waiting a long time for assistance to eat their meals. In one case a person waited 40 minutes to be assisted to eat their meal. We discussed this with the manager, who told us they would use more senior staff that were in the building to assist with meals to ensure this did not happen in the future. Relatives we spoke with told us, "Sometimes I don't think there are enough staff. If one member of staff is seeing to someone in their room it leaves the others unattended and it only needs one or two to start" and "I appreciate that a lot of the staff have been here a long time - there is no vast turnover of staff which is good". Another relative when asked if they felt there were adequate staff said, "It depends. I think when they have someone on end of life they get a bit stressed but the majority of time its ok".

We reviewed the staff recruitment records for three staff who worked at Norton Lees Hall. We found there was a robust process in place and that this had been followed. This meant that all appropriate pre-employment checks had been carried out and a check had been made with the disclosure and barring service (DBS) to ensure prospective staff were safe to work with vulnerable adults.

We reviewed the policies and processes which were in place in relation to the management of medicines. We found the policies to be detailed and robust. We saw there were temperature checks recorded each day for both the room in which medicines were stored and the fridge which was used to store medicines. The temperatures recorded were all within the safe range which meant the medicines were being stored in line with manufacturer's instructions.

We looked at the medication administration records (MARs) and found these were electronic. The electronic system had safety features, which meant that the person administering medicines could not leave a record until they had marked it as being completed. We found most medicines were supplied in pharmacy prepared and sealed trays, which reduced the risk of medication errors.

There were people in the home who required controlled medicines, for instance transdermal pain control patches. Controlled drugs (CDs) are those which need extra controls to ensure they are used as intended due to the nature of the drug and the risk of misuse. CDs need to be stored in a locked cupboard and there needs to be a register kept, which is signed by two staff whenever a drug is administered. We found the CD register to be in order and the stocks of drugs matched the records which were kept.

We looked at the use of as and when required (PRN) medicines. We found there were instructions included in the MARs to tell staff how they would know if a person may need their medicine and what expected improvement they should see. We checked some of the stocks of PRN medicines as these were supplied in original packets and bottles. We found there were some small discrepancies in the numbers of paracetamols which were in stock. The senior carer told us this was likely to be because staff had administered from the wrong person's packet. This was discussed with the senior carer and the manager.

We found the home was not clean throughout and found there were areas of malodour. We saw the first floor lounge carpet was heavily soiled and several of the armchairs were malodorous. In the entrance to the first floor dining room there was a black rubber strip to join the different types of flooring. This was encrusted in food crumbs and other debris. We observed the conservatory and the communal areas (lounges and hallways) were not clean and there was visible debris on the floors. A relative we spoke with showed us that the wheels on the walking frames were ingrained with dirt and food; the relative told us they thought the home was not clean enough.

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

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We reviewed the mental capacity assessments which had been carried out for people in the home. We found the assessments had not been carried out adequately or correctly, and the outcomes which were recorded did not match the evidence contained within the person's care records in relation to their mental capacity. For example, we looked at the mental capacity assessment which had been carried out for a person who had been diagnosed with dementia and their movement around the home was restricted as they were nursed in bed. The mental capacity assessment recorded they had capacity; however, there had been an application for a DoLS which clearly stated the person did not have capacity to make their own decisions which was the case from our observations. We saw three instances where this was the case from the four care files we reviewed.

We saw in one care file the person's relative had been asked to sign documents relating to consent and care. There was no evidence that the relative had the legal authority to give consent on the person's behalf, for instance, that they had a power of attorney for health. The mental capacity assessment which had been carried out on the person concluded they had capacity, so they should have been asked to sign themselves, unless they had made it clear their relative could act on their behalf.

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

Staff we spoke with told us they had undertaken all necessary training to support people in the home. They also told us the training was regularly updated; the records we saw confirmed this was the case. Staff told us they felt the training had prepared them for their roles and they felt adequately trained to meet people's needs.

Staff told us they had completed an induction prior to commencing their roles which had included e-

learning, and practical training for moving and handling, first aid, infection control and fire evacuation processes.

Staff told us they felt supported and they received regular supervision meetings with a senior member of staff. Staff also confirmed they received an annual appraisal which allowed them to reflect on their performance and discuss their development and any aspirations they had for progression. Two of the staff we spoke with told us they were working towards becoming senior carers and were undertaking nationally recognised qualifications through their roles to allow them to achieve this.

We observed throughout the day people were offered drinks and snacks. We observed the service of lunch on the day of our visit. We found that whilst the experience on the ground floor was calm and well ordered, this was not the case on the first floor, where staff struggled to support all the people who needed it.

We noted most people were assisted to sit at dining tables at 12:10 for lunch service at 12:30. We saw that three people on the first floor ate their meals from lap tables in the lounge. Another person wanted to stay in the lounge but had to be moved because there were only three lap tables available.

Some people had their clothing protected by care staff with a disposable blue plastic apron, and we saw that everyone had their hands wiped before lunch.

There was a person who was walking around. It was documented in their care plan they were eating a poor diet due to them not sitting to eat. The lack of lap tables meant they did not settle to eat as they wanted to be in the lounge.

People were given the opportunity to choose which meal they wanted from the day's options which on that day were Shepherd's pie or pasta bake. There were jugs of drinks provided to people on the dining tables. The television was playing loudly throughout lunch, which may have been distracting for people who lived with dementia.

We observed that all except one of the people who were sat at the dining tables could eat independently, however the remaining four people who were seated in the lounge area needed support. However after the meals had been given out there were only two members of staff available as the other staff were supporting people in their rooms. We found that when support was being given it was encouraging and patient. In one instance a person was asking for help and 40 minutes after their meal had been served a member of staff came to do that. The meal was cold and they did not eat it, but had a pudding instead.

We looked at the records which related to people having access to healthcare professionals and services. We saw people had access to a wide range of health professionals including chiropodists, GPs, opticians, dentists and district nurses.

We saw there had been some thought given to the environment to cater for the needs of the people who were living with dementia, for instance there was some dementia friendly wall art; however, there were door plaques on people's rooms which did not have their name, picture or any identifying features to allow people to find their own rooms. There was poor use of colour and contrast for instance with colour coded doors or signage to help people find their way to their room or to bathrooms and toilets.

Requires Improvement

Is the service caring?

Our findings

People told us, "Its lovely here I get up at the same time every day - I like it here", "They look after me very well - they are all very good staff".

Relatives told us, "The other day we came and [relative] was wet through - they would see to it if we asked but you just feel that if you are here you should do it - although I haven't met one staff member I didn't like" and "They all work very hard and look after [relative] very well.

We observed the interactions between staff and people in the home throughout the inspection. We found staff were kind, caring and patient when supporting people and there were obvious positive relationships seen, with laughing and joking evident. We noted during the day one person had become upset and we saw a staff member comforting them with compassion and kindness.

There were resident and relatives meetings held twice each year. The most recent of these meetings was held in August. The primary function of this meeting had been to announce the change to the management team and to offer reassurance to people that the new structure would be of benefit to them. There were also discussions and information shared about other issues in the home, including the control of the heating on the first floor and some problems which had occurred with the lift.

We reviewed the processes which were in place to ensure people had access to an independent advocate when they needed one. We did not find any evidence this was in place. We saw in one case a person lacked capacity and did not have anyone to support them with making decisions and to express their wishes. There was no evidence an advocate had been provided to ensure their human rights were respected and protected. An advocate is an independent person who represents a person who does not have capacity to make decisions unsupported.

We found records were kept securely to ensure confidential information was not accessed by unauthorised people, and we found staff were considerate about maintaining people's confidentiality.

Some relatives we spoke to told us they were concerned that people were able to wander in to their relative's rooms on the first floor, and they felt the open doors did not protect the privacy of people in the home. This had been raised with staff and requests had been made to have the doors locked when people were not in their rooms. One relative told us they had an issue with clothes and throws going missing and said they were not sure if the cause was laundry or other people going into the room, so they had requested that the room was locked.

We found that whilst people were clean and well dressed, some relatives expressed concern about the frequency of baths and showers. One relative told us "I am concerned [resident] doesn't have enough baths. Sometimes [relative] smells. I know sometimes [relative] refuses and they can't force [relative] so if I'm here I will help". We looked at the daily care records and did not find reference to baths and showers, however the manager assured us people were offered baths and showers each day.

We spoke to another relative who told us they had not been informed their relative had run out of pop socks, and they were concerned this would lead to their relative's feet becoming sore.

Three relatives we spoke with raised concerns about clothing going missing in the home, and their relative being dressed in clothes which did not belong to them, whilst other people were seen to be wearing their relative's clothing. One relative pointed out another person wearing clothing which belonged to their relative during us speaking to them; they also showed us items which were in their relative's room which did not belong to them.

We noted through the day of our visit we did not see staff asking people if they needed assistance to go to the toilet, and staff were assisting people at the point they needed personal care as they had become wet or soiled. A relative told us "I must admit [relative] always does look clean and tidy but often when I come [relative] feels wet. I tell [staff] but I worry if I hadn't visited how long would [relative] have been left? Staff wait until they've done it". One of the inspection team observed a person who was walking around clutching their stomach and groaning after lunch. Staff were very busy and did attempt to comfort them as they walked past, but did not attend to their needs. Shortly after it was evident the person had needed to use the toilet, however, had not been assisted with this and now needed immediate assistance from staff to change, so that their dignity was maintained. Another relative told us their relative had been assessed for incontinence products two weeks ago but they had still not arrived, and their relative's dignity was not protected due to this.

We were concerned staff were not respecting the dignity of people in the home and we discussed the matter with the manager who told us they would take immediate action.

This was a breach of Regulation 10 dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

A relative we spoke with said they had been involved in their relative's care plans and knew that the staff would ring them if anything changed. They told us "Yes I saw the care plan when [relative] first came in, they are updated and you can ask to see them, nothing is hidden."

We reviewed the care plans for four people. We found the care files were well organised and that each section of the plan was labelled for ease of access to the required information by care staff. We found there were life histories in each of the files we looked at, which were detailed and gave the reader insight into the life the person had led, and what was important to them.

Care plans included information on both medical history and current medical conditions. There was information relating to any allergies the person had. There were records of the medicines each person was prescribed, although we found some discrepancies between the records in the care plans and the medication administration records.

There was a care needs summary at the beginning of each file, which broke down the person's needs by time of day, which was an 'at a glance' record of the person's needs.

Throughout the care plans we saw information relating to the person's preferences and wishes, including what foods they preferred, how they liked their hot drinks, what activities they enjoyed and how they liked to be addressed.

Care plans were regularly reviewed and there was evidence current information for instance GP visits or changes to medication were included in these reviews to ensure care plans were up to date. There was no evidence in the care files that the people about whom the care plan related had been involved in the writing or review of the care plans, and no-one who lived at the service we spoke with told us they had been consulted about the contents.

We saw there was a full and varied activity schedule, which was clearly advertised within the home. The activities included entertainers, seasonal activities, for example, pumpkin carving for Halloween, exercise classes, singalongs, games and quizzes. We observed games taking place during the morning on the ground floor and during the afternoon on the first floor. The games included a bean bag game to aid strength and coordination and a quiz. Both activities were enjoyed by a number of people at each session.

There were a number of people who did not leave their rooms during the day of our visit. We were concerned these people may be at risk of social isolation as they were not spending time with other people or participating in any of the activities. We discussed this with the manager who told us they would ensure one to one activities and company from other people would be put in place.

Relatives we spoke with were complimentary of the activities which took place. One relative told us "They had a trip to Chatsworth House and had fish and chips somewhere which was just great" and another said

"They have singers in, there's always a lot going on".

We saw staff offered people choice wherever possible, which included drinks and snacks, what they ate at meal time, and what they would like to watch on television for example. We saw a group of people had chosen to watch a western musical in the afternoon after being consulted about what they would like to watch.

We reviewed the complaints process. We found there had been no complaints recorded in the home since February 2015 in the file we were given. We found from speaking to relatives there had been complaints raised by them to the home, yet there was no evidence these had been recorded, investigated or resolved. One relative told us "I am fed up of complaining. Nothing gets done and now the manager's gone, there's no consistency here".

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

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. The previous registered manager had recently left the home. There is a second home attached to Norton Lees Hall, Norton Lees Lodge and the registered manager from Norton Lees Lodge was also registering to manage Norton Lees Hall, with the support of a care manager. The care manager was new in post when we visited the home; however they had worked for the adjoining home for a number of years.

Relatives we spoke with told us there had been a lack of consistency in the management of the home over recent years, and we received mixed feedback in relation to whether relatives knew who the manager was, some said they did and some said they did not, despite the manager being in place since August 2016.

Staff we spoke with told us morale was good in the home and they told us they felt supported by the management team. Staff told us "Managers are approachable and flexible. Staff all pull together and try to help each other." and "Managers don't just drop us in it; they support us and talk us through."

We saw the management team were visible in the home throughout our visit and staff were clear on their roles and responsibilities. There were both deputy managers and senior care staff on duty to guide and advise care staff if necessary.

The registered provider had a suite of robust policies which covered all aspects of the home and its operation. We found the policies were detailed and easy to access. The policies included safeguarding, medicines management, infection control, health and safety, person centred care and staff management.

There were processes in place in the form of checks and audits to assess and monitor the quality and safety of the service. We found that whilst there was a large number of audits and checks in place they were not always consistently carried out, some did not have a clear purpose and there was very little evidence of analysis of the information the audits captured and there were no actions identified or evidenced as being completed to rectify any shortfalls. For example, the accident and incident analysis which had been carried out identified people who had, had multiple falls in the month, but there was no evidence that action had been taken to prevent this happening in the future.

We looked at the daily records which were kept for people in the home. The purpose of daily care records is to allow the reader to have some insight in to the way in which the person spent the day, what support they received and whether there were any concerns about their mood, health or general well-being. The records which were in place were not detailed and gave very little information about the care the person had required or received.

We did not see any evidence the home had made efforts to gain feedback from people in the home, their relatives or other visitors to the home in the form of any satisfaction surveys. The only feedback we saw was in minutes of the relative's meetings which had taken place, the minutes of which were not detailed.

We saw there was a newsletter produced each month, which gave updates and information in the home, there was also upcoming activities, dates for relative's diaries and photographs of activities which had taken place since the last newsletter.

We found that the registered provider was meeting the requirements of their registration as they were notifying us of any events which affected the running of the service.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not offered assistance to use the toilet regularly. People were not given their own clothes to wear and saw other people wearing their clothes

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent mental capacity assessments were not correctly completed and there was conflicting information contained in people's care records. There were no records of best interest decisions and we saw relatives being asked to give consent without there being any evidence that this was lawful.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The home was not clean and was malodorous in parts, floors and equipment were crusted in food debris.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There had been no complaints recorded since Feb 2015. People we spoke with told us they had made complaints and no action had been

taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were systems in place to monitor the quality and safety of the service, however these were ineffective and were not bringing about the necessary actions and improvements.