Bridge Care Limited

Bridgemead

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The last inspection of this service took place in July 2015 and at that time, two breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to fit and proper persons employed and safe care and treatment.

At this inspection we found six breaches of regulations. The two previous breaches from the last comprehensive inspection in July 2015 had been repeated. The four new breaches were in relation to good governance, need for consent, person centred care and staffing.

Bridgemead provides accommodation and care, including nursing care, for up to 32 older people who have dementia and other associated needs in relation to their mental health. On the day of our inspection, there were 31 people living at the home and one person receiving respite care.

There was a registered manager in place at the time of our inspection; 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.

Overall we found that quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people and ensuring the quality of service provision.

The registered manager had not made appropriate statutory notifications. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been managed.

The administration of people's medicines was not in line with best practice.

Recruitment procedures were not followed appropriately.

Care plans were not person centred. Peoples' risk assessments and the associated parts of the care plan did not provide adequate detail to enable safe and effective care.

Staff we spoke with had a variable understanding of the Mental Capacity Act 2005 and DoLS. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. There were no examples of best interest decision making on behalf of people who lacked capacity to agree to the delivery of their care.

The registered manager had made applications for Deprivation of Liberty Safeguards (DoLS) where they had been assessed as being required.

Staff had not received regular supervision and training.

People had access to healthcare professionals however records did not always demonstrate that the service had made appropriate referrals when there were concerns.

The staff had received training regarding how to keep people safe and they were aware of the services' safeguarding procedures.

There were enough staff to meet peoples' needs. We received positive feedback about the care staff and their approach with people using the service.

The provider had a complaints procedure and people told us they could approach staff if they had concerns.

We found six breaches of regulations at this inspection and will be asking the provider to send us a report of the improvements they will make.

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.

The provider failed to ensure appropriate recruitment procedures were in place.

The administration of people's medicines was not in line with best practice.

Risk assessments did not always reflect actions required to reduce risks to people.

Staff were aware of their responsibility to safeguard people from abuse.

There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The service had failed to follow the MCA with regards to the best interest decision making process for people who lacked capacity to consent.

Staff supervision was not up to date. The provider had not ensured that staff training was up to date and monitored effectively.

Care plans did not always contain enough detail on how staff should support people with their nutritional needs and food and fluid monitoring records were incomplete.

DoLS applications had been made where necessary.

Is the service caring?

Good

The service was caring.

We received positive feedback about the care and support people received.

People's privacy and dignity was respected. People and staff got on well together and the atmosphere in the service was caring, warm and friendly.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person centred.

There were systems in place to respond to complaints.

People had the opportunity to participate in activities.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's quality assurance systems and processes did not ensure that they were able to assess, and mitigate the risks relating to the health, safety and welfare of service users.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people.

People visitors and staff felt well supported by the registered manager.

Bridgemead

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 10 January 2017. This was an unannounced inspection, and was carried out by two inspectors.

Prior to the inspection, we reviewed information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

Some people at the home were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home.

As part of our inspection, we spoke with five people, the registered manager, one visitor and four members of staff. We tracked the care and support provided to people and reviewed six care plans relating to this. We looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of the service we found that improvements were needed in relation to the recruitment process for staff; appropriate checks were not completed before staff were employed. The recruitment records showed that the Disclosure and Barring Service (DBS) had not been received until after staff had started their induction in the home. The DBS check ensures that people barred from working with certain groups such as vulnerable adults would be identified.

At this inspection we saw that the recruitment process included completion of an application form, an interview and an enhanced Disclosure and Barring Service (DBS) check had been completed. However there were no previous employer references for all staff employed. We looked at the recruitment records of the last three staff employed. Two of the recruitment records demonstrated that staff being employed had provided references for each other and no previous employer references had been sought. This was despite the staff having previously been employed in the healthcare sector. There was no risk assessment in place to demonstrate how the registered manager was able to assess the candidate's suitability for the role without previous employer references.

These failings amounted to a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection of the service we found that improvements were needed in relation to the safe management of medicines. We found there were occasional gaps where the administration of medicine, or the reason it had not been given, had not been recorded by staff. There were risks to people because of a lack of accurate information about their medicines. There were other aspects of recording practice which did not follow best practice guidelines for example, hand written changes to the directions on the records of administration had not been signed to show who had made the amendments.

At this inspection we found the service had failed to make improvements to their administration and management of medicines.

Record keeping in relation to medicines administration was poor. We saw gaps in some people's charts where the nurses had not signed to confirm they had administered medicines as prescribed. In addition, we saw that some medicines had been handwritten on the MAR charts but these had not been signed or countersigned. For example, on one chart staff had handwritten an antibiotic and had noted 'Out of hours verbal from on-call GP'. This had been written on 07/01/2017, but had yet to be signed or countersigned. Despite this staff had continued to administer the antibiotic twice a day. On another person's chart staff had handwritten an antibiotic on 18/12/2016. This entry had not been signed or countersigned and a total of 21 doses had been administered by staff. The provider's medicines policy stated "If instructions are given over the phone by the GP, then a confirmation by fax should be requested". This meant that staff had not followed the provider's own policy.

Two people were having their medicines crushed. Crushing medicines can alter their mode of action and

may also result in the medicine being given "off licence". Because of this, advice from a pharmacist should always be sought prior to doing so. The appropriate advice had not been sought because there was no evidence of pharmacist input. In addition, although there was a copy of a faxed letter from the GP surgery confirming the medicines could be crushed for one person, this was dated 03/07/2015 and was signed by the GP's secretary, and not the GP. There was nothing documented in the person's care plan to indicate that they received their medicines crushed.

Staff said one person occasionally had their medicines crushed and administered in jam. There was limited documentation in place in relation to how this decision had been reached. In the person's care plan it had been documented "Likes to chew medication so GP has given consent for her medication to be crushed". There was a letter from the GP dated 10/09/2015 confirming they were happy for the medicines to be crushed but there was no evidence of pharmacist advice being sought. There was nothing documented in relation to giving the crushed medicines in jam, which would be considered as covert administration; i.e. hiding the medicine from the person. There was no evidence of a mental capacity assessment having been completed and no evidence of a best interest decision. In addition, it was unclear if the decision to crush either person's medicines had ever been reviewed.

We looked at the provider's medicines policy but there was nothing within the policy in relation to crushing medicines.

When people had been prescribed topical creams or lotions there were charts in people's rooms for care staff to sign to confirm they had applied them. However, there were significant gaps in the records which meant it was not clear whether people had topical creams applied as prescribed. For example, we looked at the records for one person who had been prescribed two different creams. The frequency of the required application had not been written on every chart. This meant staff did not have clear information about when the application was required. Records did not reflect that the cream had been applied as directed. One cream had been prescribed "twice a day", but the records showed that during January 2017, it had been applied six times.

PRN (as required) medicine protocols were in place; however staff had not always documented the reasons why these medicines had been administered. This meant it would not be easy for staff to identify any trends for when and why people might require additional medicines.

No medication audits had been carried out by the provider. We looked at the latest pharmacist advice visit from 15 June 2016. Although some of the recommendations from the pharmacist had been actioned, it was clear that the majority of the issues we noted during our inspection had already been brought to the registered manager's attention in June 2016. These included the medicines policy not following NICE guidance, the need to gain pharmacist advice in relation to crushing medicines, the need to document reasons for administering PRN medicines and that handwritten entries on MAR charts should be double signed.

We looked at self-medicating risk assessments for two people. Although the risk assessments were completed in full, the frequency of formal reviews were not always clear. For example, one person was assessed as competent during December 2014 but was not reassessed until December 2016. In addition, although mini mental health scores had been completed, the ones we were shown were completed and sent to us after our inspection. It was not clear how often these were carried out as part of the reassessment process as although documentation showed that people's care plans had been reviewed in relation to self-administering medication, some of these contained statements such as 'no change'. There were no other mini mental health assessments in place apart from the ones dated post inspection. Overall, the process for

continually reassessing people's ability to self-administer their medicines was not robust.

Care plans contained risk assessments for areas such as falls, skin integrity, moving and handling and the use of bed rails. However, when risks had been identified the care plans did not always identify measures which detailed how staff should manage the risks. In one person's care plan a risk assessment relating to their skin integrity showed the person had been assessed as having a very high risk of pressure sore development, but there was no associated skin integrity plan in place to inform staff what actions they should take in order to reduce the risk.

One staff member said that people at risk of pressure sores had air mattresses in situ. However, the care plans did not contain details of the air mattresses or the correct settings that were required. We saw there was a pressure mattress check folder and staff said the mattress settings were checked twice a day. However, we looked at four air mattresses and three of the four we looked at were set incorrectly. One person weighed 44.6 kg, but their mattress was set for a person weighing 100kg. Another person weighed 59.2 kg, but their mattress was set for a person weighing 90kg. An air mattress set at the incorrect pressure setting can increase the risk of pressure sore development as well as being uncomfortable for the person using it. In addition, some people who were at risk of skin breakdown had charts in place to record when they had been supported to reposition . The charts we looked at for one person did not specify the frequency of position changes and there were significant gaps in records. For example, one chart had no entries from 08.00 until 16.00 which indicated the person had not had their position changed for at least eight hours. Another chart indicated the person was not repositioned from 11.00 until 22.00. This meant that there was a risk that people's needs were not always being met in relation to pressure care.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was enough staff on duty to meet the needs of people using the service. We found that the staff rota was planned and took into account when additional support was needed. Comments from staff included "We do have to use agency staff sometimes, but we use the same ones, so the residents get the continuity" and "We have enough staff unless people go off sick, but hats off to the manager, she always juggles the staffing around and we always have enough during the week and at weekends." Visitors gave a variable response they said "There is a lot of agency staff at weekends, but they use the same agency so we see the same faces" and "People have to wait for help because there isn't enough staff."

The service had a policy and procedure regarding the safeguarding of people and guidance was available for staff to follow. We did find that there had been one incident that had required reporting to the local safeguarding authority and had not been reported as the registered manager had not thought that it met the threshold for an allegation of abuse or neglect. We spoke with the registered manager and were assured that they would in future report any such incident. Staff told us that they would report any issues of concern to the registered manager. Staff understood their responsibilities to identify potential abuse and knew how to report any concerns. Staff said they had attended safeguarding training and demonstrated a good understanding. Comments from staff included "I would report any concerns to the manager" and there's information in the staff room about contacting safeguarding but I would feel confident in reporting anything to [registered manager's name] first."

Incidents and accidents were recorded and cross referenced to the care files of people involved in the incidents. We saw that preventative measures were identified by staff wherever possible. The registered manager told us they reviewed the records on a monthly basis to analyse any trends and to look at further ways to reduce the risk of incidents. We looked at the records; they were very brief and did not provide an

analysis of incidents. We have further commented on the quality of records in the well led section of this report.

Requires Improvement

Is the service effective?

Our findings

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.

Consent to care was not always sought in line with legislation and staff knowledge of the MCA was limited. In addition, we did not see forms that showed people had signed to indicate they consented to the care they were provided with. For example we were told by the registered manager that one person had fluctuating mental capacity. Their records showed that they had received a flu vaccine after a relative of theirs had been asked to give permission for them to receive it. There was no record of the person providing consent or a best interest decision record for the decision made on their behalf. In addition to this there was no documentation in place to evidence the best interest process for people who did not have the capacity to consent. For example we found there were no best interest meetings for decisions relating to bed rails. There were notes within people's records stating decisions had been made in the person's best interest but there were not any accompanying recorded best interest discussions. We spoke with the registered manager and staff and found that they were not sufficiently knowledgeable about how best interest decisions should be made in line with the MCA.

These failings amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training provided by the service when they joined as part of their induction programme. Training subjects included first aid, infection control and food hygiene. Staff told us they had been given training relevant to the needs of people. Staff said they received training in order to undertake their role. One said "I had a long induction, with lots of support and training" and another said "I've just finished my Level 5 Diploma and we get lots of mandatory training too". The staff training matrix however demonstrated that not all staff had received training which was relevant to their role such as infection control, diabetes and dementia training and that refresher training was frequently out of date.

Staff said they had regular supervision sessions, although were unsure how frequently these happened. One member of staff said "I feel really well supported". Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. Records we saw did not demonstrate that supervision was undertaken as described by the registered manager; three to four times a year. We looked at four staff files; two nurses and two members of care staff. The two nurses had not received any supervision for over a year, one member of care staff had received one supervision and an annual appraisal within the last year and the second member of care staff had received two supervisions and an annual appraisal in the last year. None of these staff had received the frequency of supervisions that the registered manager has described as required.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people had been assessed as having specific nutritional needs, it was not clear how well this was managed because documentation of people's dietary intake was poor and care plans did not always contain enough detail on how staff should support people. For example, one person had lost weight. Speech and Language therapist (SALT) advice had been sought in relation to the person's swallowing difficulties and the person had been commenced on a food chart. However the detail on the charts was limited and there were gaps where nothing had been documented. On 10/12/2016, staff had documented the person ate "1 pot yoghurt, 1 chocolate pudding and 1 banana". On other days it had been documented the person ate three meals. Another person was having their food and fluid intake monitored, but again the documentation was poor. For example, the chart for 22/11/2016 had only "few sips of juice" documented for the whole day. Nothing had been documented on 03/12/2016 or 04/12/2016. It was unclear how staff monitored the food and fluid charts or whether concerns relating to people's intake were escalated because the "action" column was left blank.

In another person's care plan it referred to 'soft diet' under their nutritional needs. There was not however any further information about what this meant, for example a pureed diet or soft non fibrous foods.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed lunch during our inspection. People were asked if they preferred to eat in the dining room or the lounge and most people chose to eat in the dining room. The food smelt and looked appetising. Staff were assisting some people to eat. They sat beside them, did not rush people and made conversation during the meal. We overheard staff informing people what the meal was and asking them if they would like some more People using the service said they had enough to eat and drink. Comments included "The food is lovely, I have lots to eat and drink" and "We're well fed, the meal times are good and the tables always look lovely." One visitor said "The food is excellent here. We came and ate Christmas lunch with my relative and it was lovely."

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. Providers must at all times act in accordance with these codes. DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. Appropriate DoLS applications had been made specifically around people's constant supervision by the service.

People had access to ongoing health care. Records showed that people were seen by the GP, the district nurse, specialist nurses, occupational therapists and the dentist. We did note however that records were not always up to date and that health advice that may have been received by email or letter was not always recorded in the care plan section relating to health care advice and appointments. We have further commented on the quality of records in the well led section of this report.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. We observed some positive interactions with people. We observed one staff member telling several people "If you need me, let me know. I'm around all day".

During lunch we observed one person stood from the table and their clothing became unzipped. A staff member saw this and immediately went over and discreetly did the zip back up whilst informing the person what they were doing. People's personal care support was discreetly managed by staff so that people were treated in a respectful way. Staff made sure that toilet and bathroom doors were kept closed, as were bedroom doors, when they attended to people's personal care needs.

One visitor spoke highly of the staff. They said "People outside of here even tell me the care here is brilliant. It's the best, this is home" and "I personally think the majority of the staff are very good at what they do, they do their best".

People using the service said "All of the staff are lovely" and "All the staff are wonderful, although we all have our favourites" and "I feel lucky to be here". When one member of staff walked by, one person pointed them out and said "(staff name) is so kind, they will do anything for you." Another person said "He's [staff] lovely always smiling and checking on me."

One member of staff said "I know I do my job really well. I treat people the way I want to be treated" and "I go home knowing whoever I've been looking after has had a good day. I always ask people at the end of my shift and get their feedback."

Requires Improvement

Is the service responsive?

Our findings

Although care plans had been regularly reviewed by staff, none of the plans we looked at had any documentation in place that showed that people had been involved in their care reviews or asked whether the care was meeting their needs. Also, there was limited person centred detail within the plans. There was nothing documented to inform staff of people's preferences in relation to their likes and dislikes, what time they preferred to get up, go to bed, how they liked to dress for example, or any detail about people's personal life histories. This is significant in a service for people living with dementia as the information can aid staff in communicating and assisting reminiscence with people. There was a risk of people not receiving person centred care, because staff did not have the information available in relation to all of the people they were caring for.

Care plans were not personalised and did not take into account people's individual needs. We looked at the plan for one person who had diabetes. The plan was limited in detail and did not provide enough guidance for how staff in relation to how they should respond if the person's blood sugar dropped. Staff had documented "Check if hypo suspected", but did not describe the signs and symptoms of hypoglycaemia (low blood sugar) and how staff should respond if this was suspected.

In another care plan it had been documented that due to their memory loss they sometimes thought they could cope on their own or go home, although their house had been sold. The plan informed staff the person could become upset, but the guidance for staff was "be sensitive and aware", but there was no other detail on how staff should support the person when upset or what they could do to make the person feel better.

Some of the language used within the plans was unprofessional. For example in one plan staff had documented in the person's notes '[person's name] toileted' this was not a respectful way in which to describe the personal care received by the person.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to stay in their bedrooms or use communal 'family rooms' which included a small kitchenette and a large dining room. On the day of our inspection we observed people doing some light exercises before lunch and playing a game during the afternoon. There was an activities programme displayed throughout the building and copies of these were also seen in people's rooms. Activities included arts and crafts, singing, entertainers, poetry and church services. One visitor said "My relative really enjoys the singing" and one person using the service said "Oh there's lots going on, or you can just sit quietly, it's your choice."

There were systems in place to respond to people's complaints, and we saw the procedure for making a complaint was on display in the home. People and relatives confirmed they knew how and where to access the complaints procedure. One visitor said they had raised a concern with the manager in the past but that

this had been dealt with swiftly and effectively. The records in relation to formal and informal complaints were incomplete. Although complaints were investigated there was not always a record of the investigation for example records of conversations with staff around the incident. We have further commented on the quality of records in the well led section of this report.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems and processes did not ensure that they were able to assess and mitigate the risks and relating to the health, safety and welfare of people and others who may be at risk in the service. The quality assurance systems used by the provider and the service were ineffective in assessing where the service required improvement and implementing and sustaining improvement effectively within a reasonable timescale.

Since our last comprehensive inspection there had been no improvement in the level of service provided and some areas had deteriorated. At this inspection we identified six breaches of regulations, two of which were continuing breaches from our last comprehensive inspection. This demonstrated the provider had failed to take sufficient action in response to shortfalls previously identified.

The registered manager told us that they and other senior staff undertook audits in relation to different aspects of the home. These audits were ineffective because they were not carried out in a way that improved the service. For example infection control audits were completed annually; the last audit was in February 2016. The frequency of infection control audits did not enable the service to ensure that poor practice was addressed before it became embedded in practice. The last audit had raised a number of actions for completion; there was not however any record of completion of the actions or a system to ensure the actions were complete within a reasonable timescale.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care or aid person centred care. There was also a failure to identify recording errors and omissions in the care records and to analyse concerns. We saw records which were undated, unsigned, incomplete and incorrect. All of the care plans we saw (6 out of 32) had an element of incomplete or poor quality recording with some being significantly worse. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment. We also found that records in relation to maintenance, complaints, staff training and supervisions were incomplete or out of date.

People, their relatives, staff and professionals were given questionnaires for their views about the quality of the service. The results of surveys had been analysed, however there was no action plan to improve on areas identified as needing further progress. Some of the common issues noted were relatively simple to address such as providing staff with name badges; these issues had not however been addressed by the provider despite the last survey for people having been completed in October 2016.

People and staff had regular meetings with the registered manager and provider to discuss improvements to the service. Actions were raised as a result of meetings; there was not however any record of completion of the actions or a system to ensure the actions were complete within a reasonable timescale.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been managed. Whilst reviewing incidents at the service we noted that the provider had failed to report an incident involving the police; this type of incident requires statutory notification to the commission. This meant that the Commission had been unable to monitor any concerns around the incident and consider any follow up action that may have been required. We spoke with the registered manager and were assured that they would in future report any such incident.

Visitors said the registered manager and staff communicated with them through planned meetings and also on the phone if there was anything urgent that they needed to know. One visitor said "When my relative fell recently, the staff rang to let me know straight away" and "They always keep me informed".

People said they had regular access to the manager through regular coffee mornings. One person said "I know who the manager is and I know I can talk to her if I need to".

Staff spoke positively about the culture at Bridgemead. One staff member said "I'm well supported. The manager is really approachable and is the best manager I've ever had" and "The management team really care about the residents and the staff". Another member of staff said "I get treated as a valued member of the team. Staff are listened to."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to follow the MCA with regards to the best interest decision making process for people who lacked capacity to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The administration of people's medicines was not in line with best practice. Peoples' risk assessments did not provide adequate detail to enable safe and effective care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people and ensuring the quality of service provision.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not followed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received regular supervision and training.