Jencare Homes Limited

Asmall Hall Care Home

Inspection report

Asmall Lane
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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

Asmall Hall is a 17th century manor house, situated in five acres of grounds within a rural green belt area on the outskirts of Ormskirk. Accommodation is provided for up to 56 people, who require help with personal or nursing care needs. There is also a small unit for people who are living with dementia. The home has a minibus and trips out are arranged to local places of interest. Asmall Hall is not on a bus route, but Southport and Ormskirk are only a short drive away.

We last inspected this location on 25 March 2015 and we found several breaches of the Health and Social Care Act (2008) Regulated Activities Regulations. These related to care and welfare, assessing and monitoring the quality of service provided, safety, availability and suitability of equipment, safety and suitability of premises, management of medicines and cleanliness and infection control.

That unannounced inspection was conducted on 25th March 2015 This inspection took place on 27 April 2016, and was unannounced. During this inspection we checked if action had been taken to address the outstanding breach of regulations from the previous inspection. We found that whilst some improvements had been made, not all actions identified on the action plan submitted by the provider had been completed.

The registered manager of the service was present throughout 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.

We checked to see if medication was handled safely within the home. We found there were no care plans for "as and when medication". People's medicines were not stored and administered safely.

We found systems for identifying and managing risks at service level were present, however these were not robust and not effectively put into practice, which meant that the systems did not help to anticipate risks within the service.

We observed poor infection control practice within the home; staff failed to remove protective clothing at point of care. The home was generally unclean throughout, the décor was tired and contents and fixtures were in need of replacement.

Safeguarding procedures were in place and provided staff with guidance about reporting any potential or suspected abuse of people who used the service. However, we found that some reports of suspected abuse had not been dealt with adequately. The registered provider had a specific plan in place detailing the arrangements to deal with emergency situations including fire.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We found that the service did not have sufficient systems in place to enable assessment of a person's mental capacity prior to completing any best interest decisions.

The dining experience differed across the two units for people who used the service. We found inconsistencies in staff support for people who required assistance. Food was served luke warm and the dining experience was not person centred.

We found that although staff displayed a good understanding about how to treat people with privacy, dignity and respect, this was not being put into practice during their interactions with people who lived at Asmall Hall.

Care files contained informative life histories and were person centred, however these were not used to inform care planning. It was evident that not all of the care plans viewed reflected the person's current needs and individual preferences.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective. We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, governance, staffing, consent, dignity and respect, safeguarding service users from abuse and improper treatment, premises and equipment and meeting nutritional and hydration needs.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 consistently safe.

The registered provider had emergency evacuation plans in place for people who used the service.

Medicine storage was not temperature checked to ensure that the medicine being stored was maintained at the correct temperature.

Risk assessments did not always contain actions to mitigate the risks.

Is the service effective?

Inadequate

The service was not effective.

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

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

People were not always supported during mealtimes.

There was good signage in place within the dementia unit.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always respect people's privacy and dignity.

Staff did not offer information to the people they were supporting.

We saw that generally, people who lived at the home looked clean and were well presented.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

Care plans did not always reflect people's current needs.

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

Is the service well-led?

Inadequate

The service was not well led.

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

People and staff liked the managers and found them approachable.

Asmall Hall Care Home

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 27th April 2016, and was unannounced. The inspection team composed three adult social care compliance inspectors, a specialist advisor 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.

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

At the time of our inspection of this location, 47 people used the service. We spoke with a range of people about the service; this included 12 people who used the service and two relatives. We also spoke with five care workers, two registered nurses and the registered manager of the service. This enabled us to determine if people received the care and support they needed and if any identified risks to people's health and wellbeing were appropriately managed.

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

Inadequate

Is the service safe?

Our findings

During our last inspection of Asmall Hall in March 2015, we found concerns in the service's arrangements around the safety of medicines management and arrangements to identify potential risks, in order to protect people from harm or injury. The provider was not assessing and managing risks to people who used the service. As a result of our findings we requested the provider to send us a report telling us what action they were going to take to meet the requirements of regulations 12, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in the action plan issued following the inspection of the service in March 2015 and found continuing concerns that the provider had not met the required standard and was in breach of these regulations.

People we spoke with told us: "There is nowhere to keep my things safe". And: "I think I'm safe yes".

We checked to see if medication was handled safely within the home. We saw medication was administered by either nurses or senior care staff within the home. When we checked the training matrix, we saw that they had received appropriate training. People's medication was stored in secure trolleys, which we saw were not left unattended when not being used.

We found there were no care plans for "as and when required medication". For example, one person who was prescribed paracetamol did not have a care plan to reflect when and how this medication should be administered. There was no record of the number of medications given for variable doses. This lack of protocols for medication increases the risk of medicines overdose and misuse.

People's medicines were not stored and administered safely. Neither the room nor fridge where the medicines were kept, were temperature checked to ensure that the medicine being stored in them was being maintained at the correct temperature. This meant that the staff could not be sure that the medicine was safe for use.

The above evidence around medicines management, amounted to a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service protected people from avoidable harm and known risk to individuals. We found systems for identifying and managing risks at service level were present, however these were not robust and not effectively put into practice, which meant that the systems did not help to anticipate risks within the service. For example, we found there was a system for auditing medication errors, which was being completed by staff, however the registered manager was not using this to create action plans on how the errors would be avoided or corrected.

Risks to people from receiving care were not managed appropriately. Care plans contained risk assessments for some aspects of the care provided, such as manual handling, malnutrition and pressure ulcers. However,

actions to mitigate the risks were not always put in place. For example, the risk assessment for one person of developing pressure ulcers showed the risk was high, but no actions had been put in place to mitigate the risk to this person of developing pressure ulcers.

Records of accidents and incidents were recorded, however some documents were missing actions taken. The majority of the records included details of those involved, what had happened and details of action taken following an incident or accident. Incident and accident records did not always corresponded with the incident and accident log. We discussed the importance of completing the documentation with full details, with the registered manager as we found that staff were not always completing these fully.

The above evidence around risk management and protecting people from harm amounted to a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider took action to keep the premises and equipment safe for people to use. Records showed the service had up to date portable appliance testing (PAT) checks, a fire risk assessment and legionella risk assessment. The registered provider had an electrical safety certificate for the premises and certificates to confirm the gas boilers had been serviced. However, the home remained unclean.

We observed poor infection control practice within the home; staff failed to remove protective clothing at point of care and were seen to walk around the service in aprons and gloves that had been used during personal care interventions. This increased the risk of cross contamination across the service.

The above evidence in relation to protecting people from risk of infection amounted to a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding procedures were in place and provided staff with guidance about reporting any potential or suspected abuse of people who used the service. One staff member told us: "I understand about types of abuse. I feel confident to report this to management straight away; we are working to protect people and I would report this". Another staff member told us: "We receive safeguarding training; I understand how to report abuse and am aware of different types of abuse". We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

However we found the provider did not protect people effectively against abuse from staff. For example, staff members had been accused of shouting at people who lived at the home and incorrect manual handling. Although the provider was aware of these incidents they did not show how they dealt with them effectively to ensure people were safe. We found the provider had not provided these members of staff with supervision to monitor their performance after concerns were raised by relatives and people who lived at Asmall Hall. This meant that the provider could not be assured staff were safely providing care and treatment for people.

The above evidence in respect of not protecting people from abuse amounted to a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the inspection we checked to see that there were sufficient staff working at the home, in order to meet people's needs in a timely manner. One person told us: "Staff are so busy there isn't enough staff'. Another said: "most of the staff look after me, they are always too busy though".

We observed that the staffing levels impacted on the care and support offered to the people who used the service. For example, those who required individual support at lunch time did not receive this. We observed

that call bells rang for a long period of time before being answered.

Following the inspection, the manager sent us a 'Staffing Guideline' tool, which described the ratios of staff required to care for people at the home on each unit. However, this did not consider peoples' individual care needs and how many staff were needed as a result.

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of people who use the service.

This resulted in a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated activities) Regulations, 2014.

We checked to see that staff who worked at the home, had been recruited safely. During the inspection we looked at a sample of six staff recruitment records and saw that application forms had been completed, interviews had been carried out and DBS (Disclosure Barring Service) checks had been undertaken. The files we looked at also contained evidence that references had been sought from previous employers, before staff began working with vulnerable adults.

The registered provider had a specific plan in place detailing the arrangements to deal with emergency situations including fire. The plan provided details of information the fire service needed, such as the layout of the building and the support arrangements in the service. The registered provider had developed Personal Emergency Evacuation Plans (PEEPs) for people who used the service.

Inadequate

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

We asked staff about their understanding of the MCA. Staff told us: "I have an awareness of the MCA, but I need more training". And another said: "I have done training, but I need to review it".

We looked at staff training records and found that six out of 50 staff had received training in the MCA and DoLS.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We found that the service did not have sufficient systems in place to enable assessment of a person's mental capacity prior to completing any best interest decisions.

Care files did not contain decision specific mental capacity assessments. There was documentation that stated when a person lacked capacity, but the assessments did not show how this decision had been made. Some care files contained 'consent' forms, although not all had been signed. These forms were not specific. In the care files we looked at we found consent for medication was not clearly recorded.

We found the Registered Manager did not follow the principles of the Code of Practice for MCA and DoLS when they installed CCTV within the home. We found CCTV was recording people constantly in the hallways, and the lounge on the Mulberry unit. People's mental capacity to consent to being monitored had not been considered. We found no consent had been sought from people who lived at the home. A number of people who lived at the care home had mental capacity to consent to this monitoring, but had not been consulted.

We checked the provider's CCTV policy and found they had not followed CQC guidance on the use of surveillance. We therefore asked the provider to turn off the CCTV until they had sought consent from people who used the service. We requested to see evidence of this. This meant that the registered manager did not take consideration of whether people were capable of making their own decisions or not.

Failings identified to adequately assess a person's mental capacity prior to making decisions on their behalf amounted to a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the documentation for DoLS applications and found that there were two authorisations that had expired and the provider had not submitted documentation to renew these. The DoLS applications we reviewed that had been submitted did not include information about the use of CCTV within the home. This meant people were unlawfully restricted which is a form of abuse.

The lack of information on the DoLs applications and use of CCTV without consent resulted in a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated activities) Regulations, 2014.

At our last inspection on 25 March 2015 we found some work was needed to make improvements to the environment. The provider submitted an action plan, as requested. We checked what action had been completed in order to enhance the premises, in accordance with information sent to us by the provider. At this inspection we found that although some improvements had been made, further developments were still needed.

During the course of our inspection we toured the premises, viewing all communal areas and a randomly selected number of bedrooms. A lot of the furniture was old and did not enhance the environment for those who lived at Asmall Hall. The décor was found to be tired and worn. The bedrooms remain on a rolling rota to be refurbished.

The service had a cleaning schedule in place however shortfalls were found in the documentation for recording that this was taking place.

Some floor coverings had been replaced since our last inspection, but others were in poor condition and in need of replacement.

Failings to act upon improving the environment for people who used the service amounted to a breach of regulation 15 (1) (a) (e) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Signage in the dementia care unit had been sourced and installed. We saw people had specific 'memory boxes' outside their bedrooms to remind them of past life events.

People's care records told us about their likes and dislikes in relation to food and drink. We checked to see if people who lived at the home received enough to eat and drink and we observed parts of both the breakfast and lunchtime meals on each of the units.

The dining experience differed across the two units for people who used the service. Food was transferred to the Mulberry unit in an uncovered trolley, which resulted in the food being served luke warm. We observed that there was not enough staff on the Mulberry unit to support people appropriately at meal times. This was because four people required assistance to eat their meals and only one member of staff working on the unit was available to assist. We observed that although staff worked well during the observed period, support was not personalised and staff were unable to provide one to one support, due to needing to assist other people at the same time.

We found that people were not being supported to meet their nutritional and hydration needs. Therefore, this amounted to a breach of regulation 14 (1) (2) (b) (4) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the residential unit there were more staff available and we observed people who needed help being supported on a one to one basis. Food was puréed appropriately and food choices were separated on

peoples' plates, so they could experience the different tastes. The service lacked person centred care, an example of this was when carers were unsure if a lady had sugar in her tea, and three carers were involved in the discussion. The lady had lived at the service for six years.

We recommend that the service looks into ways to improve the dining experience to ensure that this is a pleasant experience for everyone who uses the service.

We asked staff if they received training to help them understand their role and responsibilities. Staff told us: "We have training weekly". And: "We have had training. If anything comes up we can request further training". People who used the service told us they had some confidence in the staff and in their skills and knowledge. People told us: "I think staff know what they are doing, it depends who it is". And: "Staff know what they are doing, it's just that they are always busy".

Staff supervision was not always consistent at the service. Some of the staff we spoke with said they had not received supervision for some time. The manager told us they aimed to complete staff supervision every six to eight weeks; however the records we were shown did not demonstrate these had taken place consistently. The home manager told us they would try to ensure that staff supervision was conducted more regularly.

These shortfalls in supervision of staff amounted to a breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We asked people if the staff team were caring. People told us: "If they're not busy they're kind": "Staff are always rushing around". And: "Staff listen to what they want, they are always chatting not listening".

Relatives told us: "Some of the staff are good". And: "We are satisfied other than agency workers, they couldn't know my Mum properly in such a short time, they don't know what they are doing".

The staff we spoke with displayed a good understanding about how to treat people with privacy, dignity and respect. However, during the inspection we observed poor practice. Staff entered peoples bedrooms without knocking on the door first. We also observed staff openly discussing a person's physical health in the dining room, where other people who use the service were present.

We looked at care records for six people and found that people were not involved in the care planning process. We asked people if they had been given the opportunity to be involved in writing their care plans and one person told us: "I don't know what a care plan is". Another person told us: "I get denied what I can do, they say its dementia it's demeaning".

We found that staff did not support the autonomy and independence for people who used the service and observed that people were not treated with dignity and respect. This amounted to a breach of regulation 10 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were observed discussing their personal lives whilst supporting people who used the service. Staff spoke over people who used the service. These examples did not promote a caring approach towards those who lived at Asmall Hall.

Staff did not offer explanations or information to the people they were supporting. An example of this was when one person was moved in their wheelchair from one lounge to the other, but the staff did not ask the person if they wanted to move or explain that they were going to do this or why.

We found that safeguarding referrals had been made against staff for the way they supported people who used the service. The reports stated that the staff had 'roughly handled' someone when delivering personal care.

We saw that generally, people who lived at the home looked clean and were well presented.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was personalised and met their individual needs.

During our last inspection of Asmall Hall in March 2015 we found that the registered person had not protected people against the risk of unsafe care or treatment, because the care planning process was not always sufficiently person centred and potential risks had not always been managed well.

During this inspection we found that care plan and risk assessment evaluation timescales varied throughout the care records that we looked at. Care files contained informative life histories and were person centred. However these were not used to inform care planning. It was evident that not all of the care plans viewed reflected the person's current needs and individual preferences. For example, some care plans included details such as when a person liked to go to bed or how they liked to take their medications, however this was not consistent for all the files we reviewed.

We found that accurate records were not always maintained by staff. These related to personal care charts in the bedrooms of eleven people. Care records for one person, where their falls were being monitored were not fully completed. Although these recording systems were in place, we found inconsistencies and omissions in the documentation.

We saw evidence in care files that the service was not always making the required referrals and seeking support on how best to meet people's needs. One person had a significant weight loss and there had been no referral made to the dietician. We asked the provider to complete this on the day of our inspection.

We found that the provider had not done all that was reasonably practical to mitigate risks. This amounted to a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the most recent survey results that were available. We saw people were asked about their care, the staff and the food at Asmall Hall. Some negative comments were made in response to questions, such as; 'How well do you think you are cared for' and 'How well do staff interact with you'. It was not clear to us what action had been taken in response to this, in order to improve the service for the people that used it.

Activities and stimulation were limited on the day of the inspection. Four people who used the service had been taken out to Liverpool for the day and the homes activities co-ordinators had gone with them. Some of the people who used the service told us there was not always enough for them to do and staff said that due to current staffing levels at the home, they did not have sufficient time to spend with people and engage in regular conversation. There was an activity schedule displayed in the home, which showed that regular activities were on offer.

People told us they would speak to the staff or the manager if they had any complaints. One person told us: "I would talk to matron if I wanted to". And: "I will say if I don't like it".

People we spoke with told us that if they had any complaints about the home they would talk to the manager about it. Staff told us that they would report any complaints to the manager to be investigated. There were processes in place to record any complaints received, details of investigations and outcomes, as well as any subsequent action taken.

Inadequate

Is the service well-led?

Our findings

During our last inspection of Asmall Hall in March 2015, we found the registered person had not implemented robust systems to regularly assess and monitor the quality of service provided. As a result of our findings we requested the provider to send us a report telling us what action they were going to take to meet the requirements of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance.

During this inspection we reviewed requirements outlined in the action plan issued following the inspection of the service in March 2015 and found continuing concerns that the provider had not met the required standard and was in breach of these regulations.

Audits of care files had not been undertaken at the service for the last six months. No audits of medications were being completed. The manager told us that the management of medications had been delegated to a member of staff, but this had not been overseen or checked by the manager or deputy manager of the home

We did not see audits had been conducted in other areas, such as infection control and the environment. Therefore, shortfalls which needed to be addressed in these areas had not been identified by the internal assessing and monitoring processes. Staff spoken with said they had no involvement in any of the auditing processes, but thought the managers did these.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective.

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

We found that minutes of meetings were retained and staff confirmed they had meetings periodically, so that they could get together and discuss any relevant topics in an open forum.

We did not see any evidence that meetings were being held with people who use the service to gain their views on improvement. People told us: "I've never been to any meetings". And: "No one ever asks me what I think".

We asked staff for their views on leadership at the home. One member of staff said: "The management are very supportive and are always there for me". Another member of staff said: "I have no concerns about the manager". Another member of staff told us: "Matron is the single most dedicated woman I have met in my life".

We viewed a selection of service certificates of various facilities and equipment within the home and found that these were completed and up to date.

A wide range of written policies and procedures provided staff with clear guidance about current legislation, such as safeguarding, medication, record keeping and positive behaviour support.

The registered manager had received completed residents' and relatives' surveys. However, there was no report to show the emerging themes or any action points needed.

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We noted we had been told about things we needed to know in accordance with The Care Quality Commission (Registration) Regulations 2009. The provider has also attended meetings with the local authority with a view to driving improvements for the people who use 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that service users are treated with dignity and respect and ensure the privacy of the service user. Regulation 10 (1) (2) (a) (b). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. regulation 11 (1) (3). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have suitable arrangements in place to make sure that care

Treatment of disease, disorder or injury	and treatment was provided in a safe way for service users. Regulation 12 (1) (2) (a) (b) (d) (g) (h). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that lawful authority was in place prior to a service user being deprived of their liberty for the purpose of receiving care or treatment. Regulation 13 (1) (2) (3) (5). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that support was in place to support service uses to east and drink in accordance with their identified need Regulation 14 (1) (2) (b) (4) (d). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that the premises

Treatment of disease, disorder or injury	and equipment being used was maintained to the standards of hygiene appropriate for the purposes for which they are being used Regulation 15 (1) (a) (e) (2). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service provider must ensure that there is a robust system in place that can monitor the quality of service provided. Regulation 17 (1) (2) (a) (b) (c) (f). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a). As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures.