Milewood Healthcare Ltd

Holgate House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 01 February 2016. The inspection was unannounced. This was the first comprehensive inspection for this registered provider since they took over the home in November 2015.

Holgate House is a care home service without nursing. The service provides accommodation for up to 30 older people and younger adults with varying needs that include care and support for learning disabilities, autistic spectrum disorder and/or mental health. At the time of our inspection there were 19 people receiving a service. Holgate House is located in the historic city of York with good public transport links. Off road parking is available at the rear of the building for visitors.

Holgate House did not have a registered manager. The registered manager submitted an application to cancel their registration to manage all regulated activities and have their registration removed on 15 January 2016. 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.

People provided us with a mixed response about the support and care they received. It was clear from talking with people and looking at care plans that care was not person centred and we saw that people who used the service, their relatives and friends did not contribute to people's care planning. This was a breach of Regulation 9: Person centred care under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe, but they told us they had concerns around their safety and the staff who cared for them. Where people had raised concerns with the registered provider regarding their safety, these had not been addressed.

Staff had not all received up to date training in safeguarding adults from abuse and some staff when asked, were unable to identify all the types of abuse they should look out for when caring for and supporting people. This meant that people were not protected from abuse and improper treatment. This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment.

Care plans had not been updated and staff that supported people did not have access to up to date information on people's current needs. Although some of the risk assessments we looked at were up to date, we saw these were inconsistent with their care plans and other assessments and that resulting actions had not been carried forward. There was no evidence of how people were being supported or how their risks were being monitored to keep them and others safe.

The above issues meant people were not receiving care and support in a safe way appropriate to their needs. This was a breach of Regulation 12: Safe care and treatment under the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

The service had a recruitment policy. However, low staffing levels were identified as a serious concern by staff, people and others. The registered provider told us that they did not use a staffing dependency tool and we saw there was insufficient staff, who lacked the appropriate knowledge and skills to meet people's changing needs and to keep them safe. This was a breach of Regulation 18: Staffing under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for nine staff. We saw that staff had completed an application form that included an equal opportunities statement. Files contained two references and checks had been made with the Disclosure and Barring Service (DBS).

We saw that although the registered provider had a training matrix in place and had implemented a training programme for staff, not all training for staff was up to date. Where gaps in training had been identified there were not always scheduled dates to determine when this training would be completed. This meant that not all staff had received sufficient training to carry out their roles effectively. We saw staff supervisions were inconsistent, some staff had not received supervision at all and others told us they were informal and did not have documented outcomes recorded. This was a breach of Regulation 18: Staffing under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a medication policy and administration procedure was in place along with a policy on self-administration for people. We asked staff and they told us they understood the policy. We saw staff had received some training in safe management of medication, but competency assessments were outstanding for some staff. We observed a medication round and looked at people's medication administration records. We saw staff did not always follow the policy and procedure and that staff were not competent in the medication process resulting in errors of administration and recording. This meant that care and treatment was not provided in a safe way for people. This was a breach of Regulation 12: Safe care and treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a contract in place for two cleaners however, we saw areas throughout the home that were not clean including communal areas, peoples rooms and service areas. There was a strong smell of cigarettes that was at times overpowering despite the home having a 'no smoking policy'. This was a breach of Regulation 15: Premises and equipment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People complained about the laundry facility and we saw a backlog of people's dirty clothes mixed with clean clothes and a lack of staff and equipment to undertake the task. We observed people wearing dirty clothes and who had unwashed hair. People told us that they had not received appropriate support with their personal care. We observed staff and others did not always knock and wait for a response from people before entering their rooms. This was a breach of Regulation 10: Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had received training in and had a basic understanding of the requirements of the Mental Capacity Act 2005. We looked at people's care files and we saw where applications for deprivation of liberty safeguards were required these were inconsistent and in some instances had not been completed. People told us they did not receive appropriate guidance, which included information on how to access advocacy services to ensure they understood their legal rights. This meant the registered provider did not adhere to the Mental Capacity Act 2005, which includes the duty to consult others such as carers, families and/or advocates where appropriate. This meant people might have received care and support without consent,

which was a breach of Regulation 11: Need for consent.

We saw that people were residing at the home and receiving services under section 117 of the Mental Health Act 1983. We saw no evidence that staff had received training in the Mental Health Act 1983. Staff did not demonstrate an understanding of the act which meant they did not have the required skills and competency to provide appropriate care and support to meet people's needs. This meant people were not protected from abuse or improper treatment under the Mental Capacity Act 2005. This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the kitchen in the home had no hand soap or hand towels and that daily operational records and checks for the kitchen were incomplete. This meant that the registered provider did not maintain equipment to ensure standards of hygiene were appropriate for people and others. This was a breach of Regulation 15: Premises and equipment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had been involved in discussions regarding their food and meal times. However, the resulting changes failed to recognise the individual dietary requirements and specific meal times required by individual people. We saw there was a lack of choice in food available at midday due to the lack of staff available to provide the choices on the menu.

People's nutritional charts including food and fluid charts were not up to date and lacked consistency. The registered provider told us this was in part due to staff not correctly filling the charts in or not updating them on a regular basis.

The above issues meant people's nutritional needs were not assessed, managed and documented appropriately. This was a breach of Regulation 14: Meeting nutritional and hydration needs under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity and privacy was not always respected in the home. Other people entered people's rooms without announcement, consent or due consideration. This was a breach of Regulation 10: Dignity and respect under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people did not receive personalised care that was responsive to their needs. People did not always receive care which was person centred, met their needs and reflected their personal preferences. This was a breach of Regulation 9: Person-centred care under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff, people and others told us there were no scheduled activities for people to undertake or join in with. We observed some people remained in their rooms all day and other people walked aimlessly around the communal areas or sat isolated without staff intervention for long periods. We saw three people were agitated and one showed signs of distress. This meant people were left in unnecessary isolation. This was a breach of Regulation 10: Dignity and respect under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was positive feedback from some staff and some people we spoke with about the leadership and there was a high degree of confidence in the proposed planned improvement to the home. The home was undergoing a scheme of major refurbishments. Building work was in progress and the registered provider told us the works would be completed by May 2016.

Complaints at the home were investigated and action taken in most cases. However, we did not see how the registered provider used or documented complaints and incidents as a learning tool to prevent re-occurrence. This meant that people were not protected from abuse and improper treatment. This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider showed us audits and quality assurance systems at the home. Despite these plans and registered provider spending substantial time at the home, the breaches in regulations evidenced during our inspection demonstrate that the current management systems were ineffective in driving consistent improvement.

The provider had failed to put effective systems in place to gather the views of what people felt about the quality of the service. The systems in place designed to identify and bring about improvements in the service were ineffective. We saw the provider had quality assurance and audit checks in place. Despite these checks, the registered provider had multiple breaches.

The above concerns meant the registered provider was in breach of regulation 17: Good governance under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We identified nine breaches of Regulations under 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 this 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?

Inadequate

The service was not safe.

We saw people were not always kept safe from harm. Staff had not all received up to date safeguarding training and some were unsure what signs of abuse to look out for.

Medicines were not handled appropriately and inadequate risk assessments meant people who used the service were at risk of harm.

Minimum staffing levels meant people's needs were not always met. Some areas of the service had not been cleaned to a hygienic standard.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive effective induction, training or supervision and displayed a lack of knowledge around MCA, DoLS and Best Interest meetings. This meant some people were being deprived of their liberty unlawfully.

People's mental health and nutritional needs had not always been satisfactorily addressed.

Is the service caring?

Inadequate

The service was not caring.

People did not receive appropriate care and support; their care plans were out of date and did not reflect their current needs.

People's rights to be independent and autonomous were not always upheld and people were not fully included in the decisions about their care and treatment.

Staff did not always treat people who used the service with dignity, consideration and respect.

Is the service responsive?

Inadequate

The service was not responsive.

We found that people's care plans and risk assessments did not always represent their needs or ensure staff had the information they required to help them meet people's needs.

There was a lack of meaningful activities, which meant people were left bored and isolated. Some people exhibited distressed behaviours that were not addressed by staff.

The registered provider had consulted with people about what colour they would like their flats decorated and any preferences had been taken into consideration.

Is the service well-led?

Inadequate

The Service was not well-led.

The registered provider's quality monitoring system was ineffective and had not been used to measure or ensure the safety of people who used the service and staff.

The service had been without a registered manager since 15 January 2016. However, there was a management structure in place and staff had some understanding of their roles and responsibilities.

There was some positive feedback about the leadership from some staff and some people we spoke with. There was a degree of confidence in the proposed planned improvement to the home to be completed by May 2016.

We saw complaints were investigated and action taken in most cases. We did not see how the registered provider used complaints and incidents as a learning tool or evidence that this bought about improvements.

Holgate House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 under the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 over two days on 03 and 08 February 2016 and was unannounced. On the 03 February, the inspection was carried out by two people. One adult social care inspector and one specialist professional advisor (SPA). The SPA is someone who can provide expert advice to ensure that our judgements are informed by up to date and credible professional knowledge and experience. The SPA was an expert with a mental health background who was qualified to work in the best interest framework with an individual and any associates in line with the Mental Capacity Act 2005. On the 08 February, the same team completed the visit with an inspection manager in attendance.

Prior to the inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned services from the registered provider.

The registered provider submitted a provider information return (PIR) prior to the inspection. 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.

During the inspection, we spoke to people and others at the home. This included ten people who resided at the home, four care workers, one administrative employee, one health care professional, one social worker, one senior employee and the registered provider.

We looked at records that related to people's individual care, this included the care planning documentation for six people and other care related records.

We also looked at all care workers recruitment and training records, the care workers rota, records of audits, policies and procedures and records of meetings. We observed the way staff interacted with people and

undertook an observation of the mid-day medication round and lunchtime snack in the dining room. We also looked at a number of other records including medication assessment records, fire safety records, and other audits of how the service was operating. We looked at the overall environment and how well the home was maintained. This included all parts of the home and included people's bedrooms (with their permission).

Inadequate

Is the service safe?

Our findings

People we spoke with gave a mixed response when we asked them if they felt safe. One person expressed concern about the attitude of a member of staff. They told us that they had raised this with the registered provider.

The registered provider told us and we saw the service had adopted the safeguarding policy produced by the local authority. Seven out of ten staff had received up to date safeguarding training within the previous twelve months. One care worker we asked did not have a clear understanding of what constituted abuse. They told us they looked out for person-to-person financial abuse, but other examples they gave did not relate to safeguarding situations. This meant the registered provider did not ensure staff had the skills and knowledge required to keep people safe and were not aware of their roles and responsibilities in relation to safeguarding people from abuse.

A care worker told us that people receiving a service had suffered financial abuse from a resident borrowing money and not making a repayment. They told us the police had intervened and the person came to an arrangement to refund the money. During our inspection of the home, we observed people giving money to other people receiving a service. A staff member told us one person owed £10.00 to another person and they told us "People should not be lending money."

The registered provider told us on the registered provider information return [PIR] "We have a locked door policy to keep strangers out." When we arrived at the home, we were greeted and provided access via the front door to the home by a person who used the service. We were not questioned or asked for our identity on entering the home. There were no senior staff on duty and we were taken through to the rear of the building where we introduced ourselves to an administrator. This meant the registered provider failed to ensure people and others were kept safe from visitors entering the home without appropriate checks in place.

We looked at risk assessments for seven people at the home. We saw that those that had been recently updated but were inconsistent with their care plans and other assessments. We also noted that resulting actions had not been carried forward. Therefore, staff who supported people did not have access to up to date information on people's current risks. This put staff and others, including people who received a service, at risk. People we spoke with did not understand how the registered provider managed their risks. One person told us "I can take certain risks. I'm not sure what type of risks we are talking about, but in relation to going out staff have never stopped me." This demonstrated a lack of awareness by people of how they were being supported and cared for and how any associated risks were managed to support them to live and remain independent in a safe way.

During the inspection, we were made aware of a serious incident involving a person who was vulnerable. Despite serious risks being identified, we saw from handover notes that staff were not carrying out sufficient monitoring or support to ensure their safety and well-being. Despite the risks being known and monitoring charts being implemented for this person, these were not always completed and staff were unclear if

appropriate referrals had been made to the LA under their safeguarding adults' procedures.

This demonstrated the lack of appropriate systems and procedures in place to learn from incidents and to keep people and others safe from abuse and harm.
This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider told us that they did not use a staffing dependency tool to determine staffing levels at Holgate House. People and staff whom we spoke with raised concern regarding the number of staff on duty. A care worker told us, "Staff often call in sick, it is a big issue." Another care worker we asked told us, "I was recruited as a support worker but I feel like a domestic assistant, we are firefighting." We talked with people who lived at the home and received a service, one person told us "Staff are not always around; I think they are busy doing something else." They continued, "We used to go on trips once a month when [previous manager] was here and that seems to have stopped."

The registered provider told us they brought in employees from other services not in the geographical area. A health professional told us that there were new staff all the time and this meant that they had to repeat ideas and conversations about people's support and care. They told us staff did not have enough one to one time with people at the home. As records were not up to date, it was difficult for staff to know and understand how to care for people safely.

This meant the registered provider failed to implement measures to determine the service employed sufficient numbers of suitable staff to keep people safe and meet their needs.
This was a breach of Regulation 18: Staffing under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a contract in place with a cleaning agency for two cleaners employed one and a half hours a day to clean all communal areas. We observed that one lounge still required cleaning after the cleaner had been. We observed that the shared bathrooms and conveniences had no hand soap or hand towels during our inspection. One toilet did not have a toilet seat in place, another was broken, and we saw that the extractor fans required cleaning. Some rooms had stained walls and were poorly maintained. The home did not look clean. There was a strong smell of cigarettes that was at times overpowering, despite the home having a no smoking policy. The office area was not cleaned and the bins were full. A member of staff told us "The cleaners do not have enough time to clean the staff rooms." The registered provider told us the agency cleaned the bathrooms and communal areas only. They told us "There is a new cleaning schedule being implemented but this is not in place yet."

We saw the kitchen had no hand soap or hand towels. Clean and dirty tea towels were mixed together in a pile and we saw dirty pots draining at the side of the sink with dirty water. The registered provider told us they undertook six monthly infection control audits. They told us "The infection control policy has not been implemented yet." There were ineffective infection prevention and control practices used within the service.

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

There were inappropriate arrangements for recording, handling and safekeeping of medicines. We saw a medication policy and administration procedure was in place. We asked staff and they told us they understood the policy. They told us the process had improved and that this was due to recent errors of medication administration in the home. The registered provider had notified us of these and had put in

place actions to prevent re-occurrence.

The registered provider told us on the PIR, they undertook a monthly medication audit. We looked at records and saw an audit had been carried out for medication in December 2015. This meant that regular monthly checks had not been undertaken and documented to ensure the medication policy and procedure was adhered to leaving people at risk of maladministration of medication.

The registered provider also told us on the PIR and we saw from staff meeting minutes, that recorded actions included the requirement of two staff to administer medication with both members signing the persons medication administration record (MAR). We looked at MAR charts and saw that on occasion only one signature was used. We asked the registered provider and they told us "It is not regulatory to have two signatures. It is good practice." This meant that the registered provider was not ensuring that the guidance given to staff was followed.

We saw from a MAR sheet on the day of the inspection that a person's MAR had not been signed as administered and no comment was made regarding the omission. A care worker then advised us they had just started their shift and were not aware of the omission. They told us they would update the person's MAR. The registered provider told us later "Medication can be given before 11.00 if available." In addition, they asked us "What time did you ask the staff about the medication? I am sure that it was before 11.00." We did not see notes on the omission to indicate the medication had been missed on the morning round or if the medication required administering before the lunchtime medication round. This meant appropriately documented information was not available to staff to ensure medication was administered in a safe and timely way. This also meant that staff had a lack of suitable knowledge and competency and failed to follow applicable policy and procedures.

We observed the lunchtime medication round. Two care workers undertook the round leaving one recently employed care worker on general duty across the home. The round was due to commence at 13:00 but we were advised this was delayed until 13:15 due to insufficient staff available. Three people we spoke with told us they were given their medication late. Minutes from a service user meeting on 28 January 2016 stated, "The medication was late last night, we had this at 10.30pm and I wanted to go to bed." This meant there was insufficient trained staff on duty to ensure people received their medication at the appropriate time.

Care staff did not wear or change personal protective equipment (PPE) such as gloves and aprons when providing medication for people. We observed one care worker put on gloves before administering eye drops to a person. We observed the gloves were not removed after visiting each consecutive person, which meant people were placed at risk of cross infection due to poor infection control practices.

We observed that other people in need of support interrupted the care workers on several occasions during the medication round. We observed an interruption as a person was returned to their room after becoming unwell. We observed as the two care workers attended to the person. We were advised that the person self-administered their medication, but staff had to assist with the process on that occasion. The care workers informed us that the person required Insulin, but they advised they had not been trained in the process. Staff were not clear of how to support the individual and whether medical advice should be sought. There was also some confusion regarding the needle type to be used, as two different types were available. This was recorded on the MAR chart, but the care workers advised the prescription had not been updated by the GP or the pharmacy. Neither of the care workers supporting the individual had received training in diabetes. The person asked for some additional medication that we saw was documented on the MAR chart. The care workers incorrectly advised us what the medication was for and had to be corrected by the person. This meant care workers did not have the required knowledge to ensure medication was administered to people

for the correct reasons and dosage to keep the person safe.

We observed the care workers manually counting the remaining tablets on the bed cover in the person's room. This risked contaminating the medication. We discussed this with the care workers who told us this was due to cabinets being introduced into people's rooms to store people's none controlled drugs. They told us the cabinets were too small and that medication often fell out. They told us they had no facility to undertake medication audit counts using a pill counter. They told us they used a variety of surfaces available in people's rooms. This meant people were at risk of receiving contaminated medication and staff failed to ensure they received their medication in a safe way.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs (CDs). We checked the storage and recording of CDs. CDs were stored in a locked CD cabinet within the medication cupboard that was locked.

We saw one CD relating to a person and we saw this detailed in their MAR file. We did not see a completed stock control sheet and queried this with the registered provider. The registered provider was unable to answer our question, but later told us "It is stock controlled on the CD stock book." We were not shown this at the time of our inspection. This meant we could not ensure that the records and the amount of medication held in stock balanced. This meant that care and treatment was not provided in a safe way for people.
This was a breach of Regulation 12(2) (g): Safe care and treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for nine staff. We saw that staff had completed an application form that included an equal opportunities statement. Files contained two references and checks had been made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. It was clear from files that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work at the home.

Inadequate

Is the service effective?

Our findings

We looked at how induction, training and supervisions were delivered and recorded for staff. We saw that although the registered provider had a training matrix in place and had implemented a training programme for staff, not all training for staff was up to date.

We saw the registered provider was implementing a new induction programme and that one new employee recruited by Milewood Healthcare Ltd had started this process. The registered provider told us on their PIR submission that new starters underwent a thorough 13-week induction following a comprehensive recruitment policy. Three staff had commenced employment under the previous ownership. They had not received an induction. This meant that the induction process for staff was not thorough and people may have received care from staff that did not have the skills and knowledge to meet their needs effectively.

We looked at training which the registered provider had deemed essential. We saw that seven out of ten staff had received up to date safeguarding training within the previous twelve months one had received training within the last 24 months and two had received no training. The registered provider showed us details of training that was planned for staff but that this did not include scheduled dates for staff who required training in safeguarding.

We saw that staff were supported by the registered provider to undertake service specific training to meet the individual needs of people but that this was not up to date. We saw at least two people receiving a service were diabetics. Training in diabetes was detailed on the training matrix and we saw three out of ten staff had recently completed this training. We looked at training for those staff on duty during the inspection and saw that they had not completed and were not scheduled to complete training in diabetes. Other service specific training included learning disability, risk assessment and data protection. We saw from the training matrix that no staff had completed or had been scheduled to complete this training.

Other gaps in training had been identified on the training matrix and there were not always scheduled dates to determine when this training would be completed. Examples included management of actual and potential aggression, confidentiality, bipolar, mental capacity act, food hygiene and first aid. This meant that not all staff had received sufficient training to carry out their roles effectively.

We looked at medication training for staff and saw that seven out of eight care workers had received up to date training in medication. One care worker told us "The medication training was basic and did not provide me with enough skills to undertake the medication round." Another told us "The medication training lasted two to three hours and was comprehensive." The registered provider told us medication training for staff was ongoing and included staff competency evaluations.

We saw staff supervisions were inconsistent, some staff had not received supervision at all and others told us they were informal and did not have documented outcomes recorded. We asked staff if they felt supported in their role and how often they met with a member of the management team. One staff told us "Yes, I feel supported" and "I speak with my manager whenever there is an issue." Another staff told us "As

best as I can be due to staffing, we just need to get on with it." The registered provider told us in the PIR submission "Each staff member has a monthly supervision." We looked at supervisions for staff. We saw that five staff had received supervision whilst employed by Milewood Healthcare Ltd. A care worker told us "I have not had supervision at all." Another care worker told us "I had supervision about three to four weeks ago." They told us "It was a good opportunity to talk about what was going on." A third care worker told us "What does that mean?" and "We are too short staffed."

This was a breach of Regulation 18(2): Staffing under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had received training in and had a basic understanding of the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the 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 found evidence that the service was not working within the principles of the MCA.

We asked for details of people with a DoLS. The commercial director was unable to provide us with this information. They told us that they had contacted the local authority to request this information and were still waiting for it. We were advised later in the day that three people had a DoLS in place. However, the relevant paperwork was unavailable despite us requesting to see this during our visit.
This was a breach of Regulation 11: Need for consent under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that whilst care workers helped people with their medication others remained unsupported in the home. During this time, we observed an incident. Despite staff intervention both they and others living at the home were potentially at risk of harm. The care worker told us "I am concerned for [persons] safety." We raised this with the registered provider who told us "Staff can be over concerned about people." The care workers told us that risk assessments in the persons care plan had not been updated to reflect their capacity and that they were concerned about the risks to the person, themselves and others.

A document presented for a DoLS standard authorisation form five suggested that the person was on hourly checks. We asked the registered provider who advised us they had requested the paperwork for DoLS and had just been made aware of the hourly checks. This meant the registered provider could have been unlawfully depriving the person of their liberty. We requested form five on the second day of our inspection and asked the registered provider if the person was deprived of their liberty. The registered provider was unable to advise us of the status of the person.

Another person's file contained a granted DoLS standard authorisation form five and this was in date. We saw a single related capacity assessment had been completed two months prior to the DoLS application. This meant the capacity assessment was out of date, did not reflect the recent decision that had been made and failed to provide up to date information about the person's care to staff.

We looked at another person's care file. We saw an application for DoLS that was not granted. There was a best interest assessment and a capacity assessment in place but we saw it did not reflect understanding of assessment of a person's capacity and DoLS and was not conducted in line with the MCA. This meant the registered provider had failed to ensure that MCA guidelines were followed and that information in regards to people's Mental Capacity was up to date.

A care worker told us that an individual no longer kept their money on their person, but in the safe in the home. We were told, "[Person] has responded to the change really well." We asked the care worker if the person had consented to the change and they advised they had. We looked at their daily entry notes and saw there was no mention of any discussion around the person wanting to keep their money in the safe. We looked at the person's care file. We saw there was no documentation that communicated the changes with the person. This meant the registered provider had failed to take the appropriate steps to ensure decisions were made with a person's consent and that appropriate capacity and decision-making procedures had been followed.

We saw that some people residing at the home receiving services under section 117 of the Mental Health Act 1983 [MHA]. Section 117 imposes a duty on health and social care services to provide aftercare to certain people who have previously been detained under the Mental Health Act 1983 (MHA). We saw no evidence that staff had received training in the MHA. Staff did not demonstrate an understanding of the act which meant they may not have the required skills and competency to provide appropriate care and support to meet people's needs. This meant consent to care and treatment may not always have been sought in line with this legislation and guidance.

We saw the registered provider had a policy and procedure on the acceptable use of physical restraint by staff. This stipulated "Restraint can only be carried out, where there was a strong likelihood of injury to him/herself or others." The document did not contain reference to the use of restraint of people who lack mental capacity. We spoke with staff who told us "We do not use restraint, we try to calm the person down and if they become violent we leave the room." Another person told us "I have worked in challenging situations and would like to undertake some MAPPA training." Another staff member told us "I have not had MAPPA training" and "[Person] posed a problem, but the registered provider was around to tell me what to do and I de-escalated the situation." We spoke with a health care professional who advised, "Staff need training with challenging behaviour and need to have some mental health training." It was clear that staff were unaware of the policy and procedure for restraint and lacked an understanding of how to deal with challenging behaviour and difficult situations. This put staff and others at risk of harm.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were supported to have sufficient to eat, drink, and maintain a healthy diet. The registered provider told us that the two cooks employed at the home had left. The registered provider told us they did not intend to replace the cooks. They said that as part of the forward planning the registered provider was building in kitchen areas around people's rooms to enable people to budget for and prepare their own food.

We saw that people had been involved in choosing their food. A meeting had been held and people had chosen a four-week menu based on their preferences and had decided to have the main meal in the evening with a snack at mid-day. People we spoke with seemed unaware of why the meal times had changed, but one person told us "We have a good food choice, it is Lasagne for tea and we have a snack at dinnertime."

We looked at the minutes of a service user meeting at the end of January 2016. People had been asked what they thought of the new menus. People had replied "Nice," and "Much better." One person had replied, "I don't know if I do like them, I have been having hypers!" the registered provider had asked "Is that because of the change in time of the main meals?" the person responded "Yes, but it is something my body will get used to." We saw that the registered provider had changed the meals and times based on the majority of people's feedback, but that they had not recognised people's individual nutritional needs and preferred meal times, which may put them at risk.

We looked at people's nutritional charts in their care files. We saw that food and fluid charts were not up to date and lacked consistency. Some fluid charts were not available and had not been printed out for people. We looked at two food charts that showed people had not eaten for two days. We asked the registered provider about this and they told us "That is not correct; staff are simply not filling the charts in." This meant that records did not demonstrate that people were receiving sufficient fluid or hydration.

We saw that daily medication to assist with nutrition and diet had been recorded on a person's daily notes but had not been recorded on their nutritional charts. We asked the registered provider about this and they told us "This is because [person] is not taking them." A care worker told us "[Person] has been unwell and has not been eating since coming out of hospital last week and they have since lost weight and sleep all day." We were told that the person should have had hourly checks, but we were unable to evidence this. We asked the registered provider who informed us they had no knowledge of this. We asked if a doctor had been called out, as this had been ongoing for a week, a care worker told us "We have called for the doctor to come out today." We checked and saw a doctor attended to the person later in the day.

This meant people's nutritional needs were not being assessed, managed and documented appropriately. This was a breach of Regulation 14: Meeting nutritional and hydration needs under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

This service was not always caring. People we saw did not appear to be cared for and they were not supported with their personal care. We saw people in an unkempt state. We saw people had dirty clothes and unwashed hair. We observed some people in the dining room with ill-fitting clothes and their trousers falling down. One person was dressed in pyjamas that were falling down with their underwear showing. Their mouth was covered in dinner and had not been cleaned. We observed a person in a communal area on their own. They had food and saliva on their face. The registered provider saw this and attended to the person. People were talked across during the medication round by staff and we observed minimal interaction between staff and people around the home and during meal times. This practice did not promote people's dignity.

A care worker told us "If people refuse personal care we just keep going back; we made ten attempts with a person last week, but succeeded." People were not supported with their independence. A person told us "I haven't had my hair cut and I want it cut." They told us "The hairdresser used to come here." We saw that discussions about people visiting the hairdresser had been raised in the service users meeting held in January 2016. We looked at a person's care file. We saw a care plan on personal hygiene where two showers had been recorded for the person since October. We asked the care worker about this and they told us "[Person] spends a lot of time at their friends." Another person told us "They [registered provider] are going to put an en-suite shower in for me as part of the renovation." They said, "There is a communal bathroom downstairs but I don't like using it." This meant that at the time of our inspection people were not supported with their personal care needs or preferences.

We looked at the minutes from a recent service user meeting. One person said, "I don't have many clothes so I need to wash them often" and "They [new washing machines] are rubbish, it doesn't clean clothes properly." They continued, "I like my clothes to be clean and smell nice." One person had responded "I have another complaint that every time I ask to do washing they say teatime and I never get it done because other people get theirs done first," they continued "Also no one prompts us about washing anymore, I know it's up to me and life skills and all that, but they should remind me." We looked inside the laundry room. The door was locked and there was dirty laundry on the floor outside. On entering the room, we saw five baskets full of dirty clothes and a commode. The room was disorganised. It was unclear how clean and dirty laundry was separated. We were told by a member of staff, "Residents have their own baskets and support workers put the washing on" they said "There is a back log because staff do not have any spare time."

People were not supported with their food preferences and choice. We observed the mid-day snack of scrambled egg on toast with juice followed by yoghurt. There were no staff on duty in the dining room to assist people who we observed to be struggling with their meal. We observed one care worker preparing food in the kitchen. We asked if there was an alternative to scrambled egg on toast and we were told, "We should be offering poached eggs on toast but there is not enough staff for that."

People were not supported with their personal hygiene and well-being by staff and we saw equipment was not suitable for the purpose.

We saw other examples where people's dignity and privacy was not always respected in the home. We saw site workers enter a person's room without warning or knocking whilst the person was receiving medication. We observed a person entered another person's room without knocking whilst the person received medication, as they wanted to speak with the care worker. The care worker asked them to leave. We saw staff knock and immediately enter people's rooms before hearing a response. On one occasion, we were told the person had a hearing impairment so staff just entered the room. This meant that staff did not ensure people had privacy when receiving treatment and communication with people was not respectful. This was a breach of Regulation 10: Dignity and respect under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider told us on their PIR "Care plans, risk assessments, pathway plans are reviewed and up to date." We saw staff were not supporting people according to their changing needs and that their needs had not been updated in people's care plans. We saw that care plans for people were not up to date. We asked the registered provider who said, "None of these have been updated." We saw behaviour charts were not in place for all people and that where they were staff were not following them thoroughly. Documented concerns on behaviour charts had not been transferred to the daily entry sections. This meant other staff were not always aware of the concern and were not responsive to people's care needs.

The registered provider told us "Staff have not had proper training and do not know what constitutes a proper care plan." We were told that staff were undergoing a programme of care plan training and we were shown a blank copy of a new style of care plan due for implementation. They told us "Management need to get to know people" and "Staff will rewrite the care plans once the training has finished and management will review them [care plans] on a monthly basis." This meant that at the time of our inspection, staff and management did not have an understanding of people's needs and preferences.

A care worker told us "I have worked with these people for years, I know them very well." One staff told us "Care plans are useful; the ones in place are archaic." Another told us "Care plans are due to be updated; additional information [about people] would be nice." This meant staff did not understand or provide appropriate up to date care and support to people as this was not documented. This meant people might receive inappropriate care that did not meet their needs putting them and staff at risk.

The registered provider told us on the PIR "People are encouraged to have input into their care plans." Care plans we looked at did not show any involvement or contribution by people in the way they wanted to be cared or supported. There was no evidence of any one-to-one documented support between people and staff. This meant people were not receiving person centred care.

People did not have an active part in their decision-making or assistance to make informed choice and control around their care planning documentation. The MHA s34.19 indicates that care planning requires a thorough assessment of patients' needs and wishes. We saw some leaflets in the home about advocacy. People were unable to tell us what advocacy entailed. We asked a care worker where this advice for people was documented. The care worker was unable to provide this information.

One person refused their medication and the care worker seemed unsure how to progress the situation on an individual basis. They discussed the person's refusal with a colleague and completed the administration, but we saw that they had a lack of knowledge and confidence in providing the individual with person centred care that met with their preference.

This was a breach of Regulation 9: Person-centred care under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they had not received a copy of their care plan. One person told us "Never seen my care plan" another person told us "I should have one somewhere, I don't know."

The registered provider told us on the PIR "The home ensures there are no restrictions on visitors in accordance with individuals care plans." We did not see visitors to the home, but people told us they went out with friends. We did not see where restrictions were documented, as care plans had not been updated.

During our visit, we carried out a tour of the premises. We saw the home had a zero smoking policy in place. We saw people smoked in their rooms and the home smelled of cigarette smoke. The registered provider told us "It is difficult for other people" and "It is not ideal." A person had 12 documented risk assessments for their smoking. We asked the registered provider about this who acknowledged the concerns with the person smoking and said, "[Person] will not stop smoking" and "They [person] are not compliant," they continued, "[Person] has signed the smoking agreement." There were no details in the individuals care plan, of actions in place that supported people with smoking including the use of other health professionals or information on how the registered provider prevented further occurrences or minimised the risks to the person and others living and working at the home. This meant the environment was not healthy for people and others peoples care was not being effectively managed to keep people safe and well.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We saw people did not receive personalised care that was responsive to their needs. We saw one person in their room with sensory impairment. Staff knocked, but entered the room without a response from the person. Staff told us they communicate with the person using only a pen and paper. We were advised that the person could recognise gestures but we did not see this documented. The person had returned from hospital and had not been eating. One person told us "We show [Person] tins and packets of food so they can point to choose what they want." We spoke with the registered provider who advised us that they would look at alternative methods of communicating, interventions and support for the person should they remain in the home.

Care plans had not been updated and we were unsure how often care and support reviews with people were undertaken or where they were documented. We saw from care plans that people were not involved in their support and care planning. People we spoke with had mixed feelings about living in the home. One person told us "I am ready to move on." They told us "I don't know what I need to do to move on."

The registered provider told us they needed to get to know the people in the service. They told us people needed to have their needs assessed to ensure the service was the best service for their needs and to ensure the service could still meet their needs. The registered provider said they were working with the local authority to progress assessments.

We observed some people remained in their rooms during the day. We saw one person spent the day in their room drawing. They told us they used to attend art classes, but this had stopped. We observed people walking aimlessly around the communal areas or sitting without staff intervention for long periods. We saw very little social opportunities and there were no structured plans to demonstrate how people's social needs would be met.

The registered provider told us on the PIR "Informally we have parties, Milewoods Got Talent, Annual 5-a-side Football Tournament, Snooker, Darts, Sponsored Events and house meetings." We saw no evidence of activities on offer at Holgate House. Notice boards did not contain details of activities and there was no individual timetable of activities for people. There was no games area or snooker table. People told us there was nothing to do at the home. We spoke with a care worker who told us, "Due to the shortage of staff there is very little on offer [for people] we just manage to take people to the shop." Another care worker told us, "People just sleep in the chairs; there is nothing to do." We spoke to a health professional. The health worker raised concerns around a person being isolated, they told us, "[Person] is left in their room and they only sit in the empty lounge outside their room most of the time." They said, "[Person] used to access art classes and that seems to have stopped, they responded well to being pampered." This showed the registered provider did not have sufficient qualified and experienced staff employed and failed to understand and respond to people's individual needs to keep them safe from harm.

Throughout the two days, we observed people sat in communal areas with little or no stimulation. We saw no evidence to suggest the registered provider had implemented measures to ensure people did not suffer

social isolation. The registered provider told us "Some people like to go out on their own and others don't."

The registered provider said they had started to engage with people in the home. The registered provider told us they had consulted with people about what colour they would like their flats decorated and any preferences had been taken into consideration. We saw the registered provider had a Milewood Homes Committee. The registered provider told us people from the service had been invited to discuss their views, but that they had not attended.

We saw minutes of a service user meeting on 28 January 2016 attended by seven people and the registered provider. The meeting minutes documented concerns with the registered provider. We were unable to see any action plans, timescales or outcomes because of the concerns raised by people. This meant people's views were not always taken into account and action taken to improve the quality of care they received.

The above concerns meant people were left in avoidable isolation and were not receiving person centred care and support in line with their preferences.
This was a breach of Regulation 9: Person-centred care under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff expressed concerns regarding the discharge arrangements from hospital to the home. They were concerned about the lack of up to date information. This meant the registered service did not always have or follow adequate policies and procedures for the successful transition of people between services putting people and others at risk.

The provider had failed to put effective systems in place to gather the individual views of and act on the individual feedback to what people, their relatives and others felt about people's individual personal care and support. The systems in place designed to identify and bring about improvements in the personal care and support people received were ineffective. The registered provider gave us an action plan for Holgate House based on feedback from four unnamed relatives of people in the home. The action plan was not dated. We saw complaints included 'The home is not free from offensive odours,' and 'There is not always clean linen/towels in my friend/relatives room' and 'I am unhappy with the laundering of personal clothing.' We saw that these concerns had a completion date of 31 March 2016 but that there was no interim measures to address the complaints to ensure peoples individual needs were met.

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

We looked at how complaints and incidents were investigated. We saw that the registered provider had a complaints file in place. We saw complaints were investigated and action taken.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place. The registered provider and a senior manager supported us at our inspection. The registered provider advised us that they were going to recruit a registered manager once the improvement works at the home had been completed.

There was a scheme of major refurbishments in progress at the home. Building work was underway and we saw an outside flat was decorated. The registered provider told us the scheme was to improve the design and adaption of the home for the benefit of the people who lived and worked there. The registered provider told us the refurbishment plans included development of en-suites in all flats and bedrooms, improving the lounge area, re-instating the front door and changing the outside office space into a kitchen area with a sitting room so people did not have to go into the main kitchen/sitting room. They told us the works would be completed by May 2016. However, the poor standards identified during our visit demonstrated that the registered provider was not ensuring that the premises were suitable and safe.
This was a Breach of Regulation 15: Premises and equipment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was positive feedback from some staff and some people we spoke with about the leadership and there was a high degree of confidence in the proposed planned improvement to the home.

There was a management structure in place and staff had some understanding of their roles and responsibilities. Two care workers told us that a senior care worker was normally on duty and there was an out of hour's number they could ring for assistance. One care worker told us that a care support worker was on management duty the following day.

We asked staff how they were kept up to date with best practice. Some staff seemed unsure how to respond although others told us they read policies and procedures and undertook refresher training.

We looked at the culture of the organisation and its ethos. The registered provider had an up to date statement of purpose, aims and objectives. The registered provider told us "Staff morale is better." They told us "Staff are friendlier and are interacting more" and "We are using staff from other homes to provide further guidance and support."

Management knew about their registration requirements under their registration with the Care Quality Commission [CQC] and were able to discuss notifications they had submitted. This meant they were meeting conditions of their registration.

We looked at the fire safety file. We saw there was a policy in place. Six staff had received fire marshal training and there were documented fire drills. Fire exits routes were documented along with daily inspections. Fire equipment was inspected weekly.

We asked the registered provider for copies of annual safety checks and employers liability certificate. The

information we received did not include these checks and we saw the employer's liability certificate we were given had expired in December 2015.

An Audit Action Plan was completed on the 1 February 2015. However although a number of issues required address, there were no actions recorded and no dates for completion. We saw the action plan contained reference to items not provided at the home including nurse call systems. Other references included, 'All risks identified have an up to date risk assessment and are reviewed monthly' Risk assessments viewed during our visit were not up to date.

We looked at minutes of a meeting held in December 2015. We saw that although the minutes reflected actions to be taken these were not consistently carried forward. For example, one person raised concern about the lack of soap in the bathrooms. We observed this to be the case when we visited in February.

Records viewed during our visit were not up to date, accurate or reflective of peoples current care needs which meant that staff were not always clear of the way in which people wanted to be cared for or how their needs should be met.

The registered provider showed us other audits and quality assurance systems at the home. We saw an action plan and an infection control audit action plan from December 2015. Despite these plans and registered provider spending substantial time at the home, the breaches in regulations evidenced during our inspection demonstrate that the current management systems were ineffective in driving consistent improvement.

Although audit systems were being used, there was a lack of clear action plans to record or review the date by which work would be completed. We saw the registered provider had concentrated their efforts on the renovation and improvement to the infrastructure of the home and there were very few actions, which focused on improving the quality of care for people using the service. We discussed our findings with the registered provider who agreed that there was still a substantial amount of work to be done.
This was a breach of Regulation 17: Good Governance under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 11 HSCA RA Regulations 2014 Need for consent Management and staff did not know how many people lacked capacity to make decisions and consent to care at the home and who had a DoLS. DoLS and associated paperwork was out of date and not in accordance with the MCA 2005. Where people were deemed to have capacity, there was insufficient evidence to demonstrate consent to care, treatment and associated activities had been sought. Breach of Regulation 11 (1) (2) (3) (4) and (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Nutrition charts and associated food and fluid charts were not up to date and lacked consistency. Medication to assist with nutrition was refused by a person and this was not recorded. People's individual nutritional needs were not acknowledged when changing meal times at the home. Choices available on the menu were not available due to insufficient staff to prepare food.

Breach of Regulation 14 (1) 14 (2) (b) 14 (4) (a) (b)

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 or secure for people and others. The home was not properly maintained. Standards of hygiene were not maintained in the shared living or service areas. Breach of Regulation 15 (1) (a) (b) 15(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes such as audits and quality assurance were not implemented across all domains and not effective to assess, monitor and approve the quality and safety of the service. Systems and processes were ineffective in identifying, assessing, monitoring and mitigating the risks to the health and safety and welfare of service users and others. Ineffective audit and governance systems. Breach of Regulation 17 (1) 17 (2) (b) (c) 17 (2) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing A dependency tool was not used to determine staffing levels. Numbers and deployment of staff was ineffective.

Supervision, appraisal and development of staff was inadequate.

Low staffing levels identified as a serious concern by staff, people and others at the home.

Insufficient qualified staff with appropriate experience to care for peoples individual needs.

Breach of Regulation 18 (1) 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support was not person centred with no group or person centred activities. Care and support plans had not been updated and did not reflect people's preferences. Care and support did not meet people's needs. People their friends and relatives were not involved in their care planning. Breach of regulation 9 (1) (a) (b) (c) 9 (2) 9 (3) (a) (b) (c) (d) (e) (f) (g) (i)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect and were not supported with washing and personal care. Staff and others did not enter people's rooms in a dignified and respectful manner. Care plans were not updated to reflect people's personal preferences. Breach of Regulation 10 (1) 10 (2) (a) (b) (c)

The enforcement action we took:

Warning notice

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risk assessments were incomplete or inconsistent with care plans and other paperwork. Systems and processes for risk assessments, prevention and awareness were inadequate. Medication policies and procedures were not adhered to by staff and there was a lack of medication awareness, timely administration, recording and control of medication. Breach of Regulation 12 (1) (2) (a) (b) (c) (d) (f) (g) (h) (i)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were inadequate systems and processes to effectively investigate, and prevent abuse of people. There was a lack of awareness and training by some staff of what constitutes abuse. Care plans were not up to date and did not reflect people's needs or protect people from neglect. Breach of Regulation 13 (1) (2) (3) 3 (4) (a) (b) (d) 13 (5)

The enforcement action we took:

Warning Notice