HC-One Limited

Alexander Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 14, 15 and 17 January 2019. Alexander Care Centre provides care and accommodation for up to 78 people. At the time of our inspection there were 73 people living at the service, some of whom were living with dementia. Care and support is provided in a purpose built care home, across three units. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our previous inspection on 10, 19 and 25 May 2016 we found a breach in regulation in relation to safer recruitment practices because there was a potential risk that staff employed were not suitable to work with people. We then completed a focussed inspection on 7 June 2017 to follow up on the breach of regulation and we found the service now met the legal requirements.

At this inspection we found new breaches of regulation. These were in relation to staff recruitment, levels of staffing, safeguarding records, mental capacity assessments, quality of care records and ineffective audits.

There was a new home manager who was employed at the service in October 2018. During this inspection the manager was not available as they were on extended leave. An interim manager was supporting the service and had been in post for three weeks. There was no registered manager in place at the time of the 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 found safer recruitment processes were not always followed. This meant there was an increased risk that unsuitable staff could be employed at the service. On the day of the inspection there were enough staff deployed in the home to meet people's care and support needs, although one member of staff was absent. However, people and their relatives told us that there were fewer staff available at weekends.

There were systems in place for staff support. However staff records showed that they did not receive regular supervision, appraisal and training as required by the provider.

There were systems in place for monitoring, reviewing and driving improvements of the service. However, many of the actions on the improvement plan had not been implemented to improve the service.

There were established systems in place that protected people from the risk of abuse and harm. Staff completed safeguarding training, but this had not been renewed as required. Staff did not always report allegations of abuse promptly.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service supported this practice. Staff understood how to support people who were unable to make decisions for themselves. People gave staff their consent to receive care and support to meet their needs.

Potential risks for people were identified and a plan was in place to monitor and manage them. Care records were person centred and considered people's needs and care plans were regularly reviewed. People were encouraged to make choices about their care and support needs. People were supported with health care support when their needs changed.

People took part in activities and were supported to do things they enjoyed and were interested in. People were supported to maintain their religious practices as they chose.

People said staff were kind and caring and provided them with care and support that showed they were respected and promoted their dignity and privacy.

People had enough to eat and drink throughout the day. Meals were provided that met people's needs and preferences. A menu was provided which people could choose their meal from.

People were confident about raising concerns with staff if they were unhappy. There was a complaints process in place so people and their relatives could make a complaint if they were unsatisfied about an aspect of care.

Staff supported people when they required end of life care and support. Staff had training in palliative care and end of life support.

The service was being managed by an interim manager. They received some support from another one of the provider's home managers and two senior managers.

We found four breaches in regulation relating to consent to care, safe care and treatment, good governance, staff support and staff recruitment.

Further information is in the detailed findings below. 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?

Requires Improvement

The service has deteriorated to requires improvement.

Pre-employment checks were not always completed or returned. This increased the risk of unsuitable staff working with people.

There were enough staff available to support people. However, people and relatives told us that staffing levels were low during the weekend.

Staff understood the provider's safeguarding processes to help them protect people from abuse and harm. But these were not always reported to the local authority in a timely way.

Staff identified risks to people. Management plans were developed so staff had guidance to help them to manage and mitigate those potential risks.

People's medicines were managed safely. Each person had their medicines as prescribed.

Is the service effective?

Requires Improvement

The service has deteriorated to requires improvement.

There was a system in place for staff support. However, staff did not have consistent supervision or an appraisal. Staff completed training although this was below the provider's recommended staff training levels.

People were supported to consent to care and treatment. Staff understood of their responsibilities in relation to the Mental Capacity Act 2005.

There was a chef on site who prepared and cooked meals for people. A menu was available for people to choose from.

People had access to health care support as needed.

Is the service caring?

Good

The service was caring.

People said staff were caring and compassionate. The interactions between staff and people were friendly and respectful.

People made decisions on how they wanted to receive their care and support.

Is the service responsive?

Good

The service was responsive.

Each person has an assessment of their care, treatment and support needs. These were reviewed on a regular basis.

There were activities provided which met people's interests and cultural needs.

People made choices about how they wanted to have their care and support provided.

There was a complaints system in place. People were confident to make a complaint about the service if they were unhappy about an aspect of the service.

Is the service well-led?

Requires Improvement

The service has deteriorated to requires improvement.

We found some the quality checks in place did not identify and effectively address the issues we found.

There were interim management arrangements in place at the service.

Staff understood their roles and responsibilities but did not always have the opportunity to identify and develop their learning and professional needs.

There was little evidence to show the service had developed links with local community groups. Staff attended and contributed to regular meetings with health and social care services.

Alexander Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 14, 15 and 17 January 2019 and was unannounced. We informed the management team we would be returning for a second and third day. The inspection team consisted of three inspectors and two experts 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the previous inspection report and notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We completed general observations of the service and how staff and people interacted together. During the inspection we spoke with 14 people and seven relatives. We also spoke with the interim manager, wellbeing co-ordinator, the area quality director, regional manager and five care workers.

We reviewed 15 people's care records, medicines administration records, 20 staff recruitment files and information relating to the management of the service.

After the inspection we received feedback from three health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

People and relatives said they felt safe living at the service. Comments included, "I feel very safe here" and "I feel safe and comfy."

Despite this feedback we found that the service was not always safe for people.

The provider had a recruitment process in place to ensure suitable staff were employed at the service. However, we found that safer recruitment procedures were not always followed and records were incomplete. For example, eight members of staff did not have evidence that Disclosure and Barring Service checks had been returned before they began working with people. One member of staff had a basic check and not an enhanced check as expected for staff working in care services.

Also the provider's audit stated a DBS should be undertaken every three years, however on eight staff records there was no evidence of this. The home's action plan had identified that they did not know the total numbers of staff with valid DBS. This meant that there was a risk that unsuitable staff were employed at the service providing care and support to people.

New candidates provided proof of their right to work in the UK and provided supporting documents for their application. However, we found three members of staff worked with people before previous employer references were received and another three members of staff had job references from employers not identified on their application form. This meant that people were at potential risk of being cared for by unsuitable staff. We discussed these concerns with the manager during feedback at the end of the inspection and we were not provided with an explanation for these concerns.

These issues were a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had assessed the level of staffing to ensure people were cared for safely. During the inspection we noted there were enough staff around and available to support people. People and relatives gave us mixed views on the numbers of staff. People's comments included, "The night staff, it's the same as day staff." Relatives said, "There's a thin level of staff, especially at the weekend. It's a very big Company. The staff are moved around and they change often" "There is an empty dining room downstairs but they won't take residents there because they don't employ enough staff to escort them up and down" and "The staff are pushed. On the weekend it feels like there is more agency people."

We looked at the level of staff available to support people safely and reviewed the staff rota from 24 December 2018 to 20 January 2019. We requested the service dependency tool, however at the time of writing this report we had not received this. We found that 12 members of staff each worked over 48 hours weekly and on two occasions there were two fewer staff on duty on the weekends. The home's action plan in July 2018, had identified their plans to improve the level of staffing by undertaking a review of staff deployed in the home and also ensuring that staff who worked over 48 hours signed a waiver. Staff told us "It used to

be short staffed, the management has enough staff and they are fixing the issues", "With enough staff to contain the unit otherwise it gets anarchic" and "Big issue is short staff can't do enough one to one."

Detailed accident and incident records were maintained. Staff completed reports on accidents and accidents that occurred at the service. The provider's electronic systems allowed senior managers to share trends and provide staff with support for further learning from incidents. However, we found concerns with the fire safety at the service.

We found the fire safety at the service increased the risk of fire. For example, staff followed a fire safety process which stated staff had to go to that area to see if a fire was in the home before the London Fire Brigade were called. We were concerned that a delay in finding a fire could have a potential impact on people's health and well-being. In addition, the London Fire Brigade's fire safety officer had completed a fire safety check at the service and found a number of concerns about fire safety. They found the maintenance of emergency lighting had not been organised, planned or completed, several doors marked 'locked fire doors' were found unlocked, the laundry room fire door was wedged open, a store cupboard held paper records that was placed inappropriately on top of a fridge increasing the risk of fire. In addition, three storage rooms around the home had gaps in the walls, ceilings or had inappropriate sealants in those area. The conclusion was that the fire safety at the home was inadequate, not suitable or sufficient. This meant that there was a potential risk of fire in the service impacting on the health and well-being of people, relatives and staff. The outcome of the fire risk assessment was discussed with the manager including details of areas of potential fire risk.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of harm and abuse. Staff understood their responsibility to identify and report allegations of abuse. Records showed that staff had not always completed updated training in safeguarding adults. A health care professional told us, "The home has been slow in following safeguarding processes e.g. reporting safeguarding concerns and providing necessary documentation within agreed timescales." Records showed that the management of safeguarding allegations had improved.

People had an assessment of risks related to their health and well-being. Staff identified people's needs and treatment and the risks associated with their individual needs. When risks were identified a management plan was put in place. Records showed staff had identified risks associated with falls, mobility, transfer, mental health, eating and drinking and pressure area care. We saw a risk assessment that identified a person was at risk of weight loss. We saw records were competed to monitor this. The person had a food chart in place and regular weight checks were recorded. Changes in their condition were reported to the GP so that they could provide advice. The risk management plans were followed by staff to mitigate these risks and keep people safe. However, we found the monitoring charts were not always completed correctly, for example, we saw three positioning charts had not been completed and the frequency of repositioning was not recorded. This meant that people were at a potential risk of developing pressure ulcers.

There were systems in place for the safe management of people's medicines. Staff were trained in the safe administration of people's medicines. People confirmed they had they medicines as required. There were systems in place for ordering medicines that ensured there were sufficient supplies. People did not always have a 'PRN' protocol in place and we asked for these to be sent to us, but we had not received them at the time of writing this report. Each person had a medicines administration record (MAR). When we checked the MARs we found these were completed accurately and reflected people had their medicines as prescribed.

Staff understood how to reduce the risk of infection. There was an infection control policy in place. Staff used gloves and aprons to reduce the risk of infection. People said they felt the service was kept clean and tidy. People commented, "It seems nice and clean and tidy" and "It's a clean nice place." However, we found a bathroom on the ground floor did not have hot water for people to wash their hands and we saw a used continence pad discarded on the bathroom floor.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who did not always update their knowledge and skills to ensure they were able to meet their needs. There was a system for staff to receive support in their jobs. The provider had arrangements for staff to complete training, supervision and a yearly appraisal. This arrangement was also confirmed by the manager in a staff meeting in October 2018. Records showed that staff had completed training in safeguarding adults, medicines management, infection control, moving and handling and health and safety.

However, we found that staff did not complete all mandatory refresher training and some had expired and due for renewal. The provider's training included equality and diversity, emergency procedures, safeguarding adults, fire drill, food safety in care, health and safety, infection prevention and control, medicines management and safer people handling. The home's action plan in July 2018, had identified that all staff who had overdue or outstanding safeguarding training should be complete this as a matter of priority. Despite this we found that 35% of staff training in safeguarding and 42% of staff training in infection control was overdue. This meant that staff did not update their knowledge and skills and were not kept up to date about current best practice guidance to help them support people effectively. This practice was not in line with the provider's expected completion rate of 85% for staff training in line with their roles.

Staff told us that they had regular supervision. However, the records we saw showed staff did not have supervision in line with the provider's requirements. On one occasion we saw a member of staff signed their supervision record but there were no details recorded. We also saw the same duplicate information in four members of staff's supervision notes.

We also found that staff did not have the opportunity to discuss and reflect on their daily practice, strengths, areas for improvement or their professional training and development needs because they did not always have an appraisal. Records showed that 45 out of 54 members of staff did not have an appraisal in 2018 with 14 staff who had not had an appraisal since 2016. This meant that staff support was not sufficient to help them identify their needs and improve their performance and skills to ensure they cared for people effectively.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence to demonstrate that nurses were supported to maintain their registration with the Nursing and Midwifery Council (NMC).

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 with appropriate legal authority. In care

homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). People's care records contained a mental capacity assessment and best interests meeting decisions. We checked whether the service was working within the principles of the MCA. We found that staff understood their responsibilities regarding the DoLS process.

People consented to receive care and support. People understood their care and support needs because staff discussed these with them. One person said, "They ask permission before they do anything." People and relatives were given information to help them understand their care records and were asked to sign these to give their consent .

People had enough to eat and drink. Meals were prepared and cooked onsite for people. However, we observed the tablecloths in the dining rooms were dirty although they had been set for dinner. There was a menu displayed in the reception area and this had details of the meal choices. There were water and juice dispensers in the lounge areas and people could help themselves. When people required specialist support to eat this was provided to reduce the risk of choking. For example, a person required a soft mashed food with gravy. The person also required a two-handed beaker at all times while drinking and they needed to be supported to sit upright while they ate. We saw staff support people safely with their needs.

Each floor of the home had a kitchenette area where hot drinks were made and snacks were available including chocolates, crisps, and fruit. People said they enjoyed the meals provided for them. Comments about the quality of the meals included, "Always plenty of food and always a choice, if it isn't wanted, they will make what they can, and you can get seconds", "They know what everyone likes, my favourite is roast with roast potatoes, any roast meat will do" and "Very good food, always enough choice."

People were supported to access healthcare services. When people became unwell, staff contacted health care professionals for additional treatment. People said they saw the GP when they needed and when they were unwell. One person said, "I have a bad toe, they said they had called the doctor to come and see it this morning." People had access to specialist support when required. Records showed staff had made referrals to health and social care professionals to help them meet people's needs effectively. For example, a dietitian was involved in a person's treatment when they experienced unintentional weight loss. The dietician provided a food plan which detailed the fortified meals they required. Staff completed food and fluid charts to monitor the person's food and fluid intake. This also helped staff to follow the dietician's professional guidance to help the person maintain their health.

Good

Is the service caring?

Our findings

People and their relatives said staff showed them kindness and were caring. Comments included, "They bring me everything here. I'm quite satisfied", "We got a nice greeting the day my mum moved in. We brought in a dementia clock for her to feel comfortable" and "The staff are pleasant to speak to. Hopefully they are nice to her also when I am not here." People and relatives were treated with respect.

People, staff and relatives spoke with each other in a respectful way. We saw that staff spoke with people in a calm manner and responded to them in an appropriate way.

Care, support and treatment was carried out in privacy. People were supported with their needs in their bedroom. This meant that people's dignity was respected while they were receiving care from staff.

People made decisions about their care and support. Care plans were developed with staff, people and their relatives. People's ideas and requests were recorded, which meant that staff were aware of people's preferences.

Staff supported people to be as independent as they were able. People had access to communal areas within their home. There was a small café at the reception area for people to enjoy and make drinks for themselves and relatives who were visiting them. People maintained relationships with others who were important and mattered to them. We observed people receiving visitors and staff made them feel welcome at the service. Comments included, "My [relative] comes when he/she has time. The family come", "We will be visiting regularly" and "I've still got all my family around who come and see me. If something happened to me, they would be here. I'm not worried about anything. Things seem to be going well."

Good

Is the service responsive?

Our findings

People received a service that was responsive to their needs. Each person had an assessment of their care, support and treatment needs. The assessment outcome helped staff decide whether a person's needs could be met at the service. Staff collected information from people, relatives and health care professionals to enable them to make a decision. Assessments were person centred because people were involved and contributed to them. People gave staff information about themselves that included their likes and dislikes, hobbies, interests, family history, health conditions, positive aspects of their life and things that were more challenging for them. People had continued assessments to ensure the information captured people's current needs and to ensure staff and the service continued meeting them.

Following the outcome of the care assessment staff developed a plan of care. These provided staff with sufficient information to care for people in line with their needs and in a way that they chose. Care plans detailed each area of a person's support. For example, one person had a care plan to manage their ability to walk. The care plan stated that they needed to have their walking aid with them at all times to ensure they were safe whilst walking. Care plans were reviewed on a regular basis with people. Any changes in care were recorded and the care plan was updated so staff had access to accurate information about people.

There were two experienced activities co-ordinators at the service. People were encouraged to take part in activities and we saw people were involved in a variety of activities. People were playing floor games, were being entertained by professional performers, singing karaoke and others were listening to music of their choice. A relative said, I'd like to take my mother out. I have asked. They said that there are a few wheelchairs. They took them out on a bike once, on low bikes. They had a couple of barbecues in the summer. Even in the winter they could take them out for a little walk around here.' People were supported to be alone and enjoy their own company if this was their preference. Comments included, "I go to listen to the music", I enjoy sitting in the garden. When I'm sitting here I can see the greenery, it's quite nice to look from here", "My relative does not take part in activities on the whole. She/he prefers to read in the room", "[My relative] will like watching the birds, sitting out in the garden when the weather is good and "[My relative] has the local home library visiting scheme. We take six books per month."

The service supported people to meet their cultural and religious needs. For example, we noted that people were listening to music they grew up listening and dancing to. Staff played music from the Caribbean for people who were seated in one area of the home. Staff said that people chose to listen to this music and often sang along to it. One person said "Yes, I do enjoy this music, my favourite." We noted that people were enjoying this activity and they were smiling and singing in time to the music.

The chef told us that they provided meals that met people's cultural needs. Staff said people requested meals they enjoyed eating from their childhood. The kitchen staff prepared Caribbean meals for people to enjoy these home cooked meals.

People continued practicing their religion. Each week staff arranged for people to attend a religious service at the home. People told us, "The religious priests come downstairs, hymns bring people together" and "I

believe in God and enjoy worshipping." A care worker added, "At night time staff do pray with residents when people want to pray and sing and read the bible, if people want this."

There were systems in place to make a complaint. People understood how to tell staff when they were unhappy about an aspect of the service or care. Relatives said they were confident about speaking to a member of staff if they had a complaint. People commented, "I would complain to the manager or the staff. No complaint", "Complain to a nurse if I needed to" and "I'd complain to a nurse." Staff gave people and relatives sufficient information about how to make a complaint and how this would be handled. The management staff managed complaints in line with the provider's guidance and the complainant was provided with a response following the investigation into the complaint.

People had plans in place for end of life care. People were encouraged to make decisions about how they wanted the end of their lives to be and these decisions were recorded in an end of life wishes care plan. People discussed whether they wanted to remain at the service or go into hospital when they became unwell and required specialist palliative care and treatment. People's decisions were recorded, and staff had access to this information, so they were aware of the action to take at that time. Staff obtained specialist support and advice from a local hospice and regular monitoring took place including monitoring of pain and skin integrity.

People also had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place where appropriate. This was decided by health care professionals in consultation with the person and their relatives. These were signed by the GP and placed on people's care records, so staff were aware of these details.

Requires Improvement

Is the service well-led?

Our findings

The service had a manager. However, they were not available at the time of this inspection. The management of the service was covered by an interim manager with support from the provider's senior managers.

People gave us mixed views on the management of the service and whether it was well led. People and relatives did not know who the manager of the home was. Comments from, "Here if you got doubts tell them they'll fix it. They do something about it", "I haven't met the manager" and "I don't know who the manager is, there are so many nurses I have a chat with" and "[Name] is the manager." A health care professional said, "The residents, relatives and home staff of Alexander, require a stable and sustained environment to ensure progress will continue" and "Until the company employs a permanent effective home manager, I will not feel confident that existing changes will progress."

There were systems in place to monitor the quality of the service. We found that the quality audits did not find all the concerns we found. Where an issue was found this was recorded and an improvement action plan developed. However, we found that actions had not been taken to improve the service. For example, staff did not complete all of the provider's training, and supervision and appraisals did not take place in line with the provider's recommendations. In addition the quality of staff recruitment records and food intake and re-positioning forms were not always completed appropriately. A health care professional told us, "I have undertaken documentation quality audits. There were several shortfalls identified, in an effort to assist them address these actions." The provider's senior manager also undertook audits of the service and they had an oversight of the service performance. The external audits showed that the quality of care was monitored and met some of the provider's requirements. We found further action was required to improve the quality of care.

An internal audit completed in July 2018, found that 'improvements are needed to the use of the home's quality assurance, information and clinical governance systems so they effectively support continuous improvements.' This had not yet been fully addressed at the time of our inspection.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some of the language used to describe people needs and requirements was not in line with good practice and person-centred care planning. For example, we noted two people's care plans written by staff used words such as 'moaning' and 'quite difficult to manage'.

We recommend that the provider seek advice from a reputable source to provide staff with effective person-centred training.

Staff had mixed views about working at the service. Staff comments included, "Things here were really awful but it has improved with this manager", "The [interim] manager is good, she listens" and "The senior

managers are helpful, and it is nice to see them around."

The Care Quality Commission were informed of incidents to enable us to take appropriate action if required.

There were staff meetings at the service. However, in the last year, these did not occur on a regular monthly basis. This meant that staff were not always able to share their knowledge and learn from colleagues, to enable them to be more effective in their role. Meetings were used to discuss any issues related to the service and news from the provider was also shared with staff. Meetings were recorded and staff who were unable to attend could read the minutes to gain an understanding of the discussions held.

People attended regular residents' meetings. These meetings enabled people and relatives to ask questions of the manager. People commented, "I attend relatives meetings. They are more attended now than before, with the previous manager" and "Recently I missed a relative's meeting and I got a letter to tell me what they discussed." People could raise concerns and ask questions at these meetings and were provided with meeting minutes. People and their relatives were asked for their feedback about the quality of the service. People's responses showed that they were happy living at the service. One person said, "Managers ask for feedback. I try to give feedback. I'm sure I would recommend here to another person."

Staff had working relationships with health and social care services. Regular meetings took place with staff and health and social care professionals. A health professional told us, "The previous home manager had no clinical background, and therefore staff spent a lot of time at Alexander, in an effort to support the management team and we appeared to make some progress." A social care professional added, "There has been a number of safeguarding issues and primarily during the tenure of the previous manager. There has been short periods of management and gaps in management since 2015. This will not assist the maintenance of any quality improvement that may take place."

These relationships did not always benefit people because records showed the provider did not always welcome support from health and social care staff to improve the service and care people received. For example, the health authority had provided training for care staff in homes in the borough of Lewisham however the attendance for this training was, 'very poor in comparison to other Lewisham homes.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure service users were protected from the risk of fire because risks associated with the premises were not identified and managed safely. 12(1)(2)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always maintain an accurate, complete and contemporaneous record in respect of each service user or staff. Systems for the monitoring, reviewing and improving the service were not always effective. 17(1)(2)(B)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The recruitment procedures were not followed to ensure suitably skilled and experienced staff were employed at the service. 19(1)(a)(b)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were suitably qualified, competent, skilled and experienced to provide care and support to service users. 18(1)(2)(a)