Baytree Community Care (London) Limited

Holmwood

Inspection report

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06 December 2018

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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

This was an unannounced, comprehensive inspection, with visits completed on 26 November and 6 December 2018.

Holmwood is a 'care home' for people with mental health conditions and learning disabilities. People in care homes receive accommodation and 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.

The service was registered to have 32 people, there were 24 people living at the service at the time of the inspection. At our last inspection on 16 and 17 March 2017, we rated the service good in all inspection key questions.

Holmwood consists of one large house, with bedrooms, communal bathrooms and toilets across four floors, communal lounges and dining's areas on the ground floor.

The service did not have a registered manager in post. '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.' The service had not had a registered manager since December 2017. At the time of the current inspection, the deputy manager was acting as manager on a temporary basis, with a replacement manager due to start in post January 2019.

At this inspection on 26 November and 6 December 2018, we found the evidence to support an overall rating of Inadequate.

During this inspection we identified that the service was failing to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for safe care and treatment, protection of people's privacy and dignity, adherence to the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards including sourcing consent, management of people's nutritional and hydration needs, provision of person-centred care, good governance, meeting the requirements of fit and proper persons and safe staffing. The provider was also in breach of the Care Quality Commission (Registration) Regulations 2009 due to not consistently submitting notifiable incidents to CQC.

During this inspection, we identified serious concerns in relation to staff competency in the safe support of people experiencing mental health conditions. Extremely poor cleanliness of the environment and lack of infection prevention control measures which was impacting on the care people received. There were significant shortfalls in the assessment and mitigation of risks to people using the service.

The service had poor governance processes in place for monitoring standards and quality of care provided.

We requested in writing for the provider to make improvements to the service between our first and second inspection visits, we identified a lack of governance and provider oversight in response to our requests. Staff did not complete audits in areas such as infection control and the quality of care records, this was reflected in our findings of the condition of the care environment, the quality of documentation and poor standards of care being provided.

Staff were not implementing training and recognised good practice in the care and support provided to people living at the service. People's records and staff's understanding demonstrated a lack of adherence to the Mental Capacity Act (2005). Staff did not recognise or understand the risks and support needs of people diagnosed with mental health conditions.

Low staffing levels significantly impacted on people's access to meaningful activities and care records lacked detail in relation to people's hobbies and interests. There was not an up to date, daily activity timetable, and people told us there was not enough to do.

People were not consistently treated with care and compassion, and their privacy and dignity was not always protected. The condition of the care environment was not conducive to the provision of high quality care.

At this inspection we found serious breaches of Regulations 9, 10, 11, 12, 14, 17, 18, 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Registration Regulations 2009 . These breaches were assessed by CQC as extreme, as the seriousness of the concerns meant that unless we took the action we believed people would be at risk of harm. The overall rating for this provider is 'Inadequate'.

On 10 December 2018, CQC used its urgent powers to keep people safe, and varied the conditions on the provider's registration to remove this location. This means that it can no longer provide any regulated activities and is closed.

The provider appealed against this decision to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. The appeal hearing was held on 28 and 29 January 2019, the decision was made that CQC took appropriate action in light of the seriousness of concern, and the appeal was dismissed by the tribunal judge.

Other stakeholders including the local authority supported people and relatives to find other homes or alternative care arrangements. By 12 December 2018, all people living a the home were safely moved to alternative placements.

Full information about CQC's regulatory response to any concerns found during inspection is added to reports after any representations and appeals have been concluded. You can see the enforcement action we took at the end 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

The care environment was unclean throughout the service, with no completion of infection prevention and control audits. This placed people at significant risk of harm

Staff did not assess and mitigate risks to people's safety and welfare

Significant environmental risks in relation to areas such as fire safety were not well managed or recognised by the management team. Action was not taken by the provider to mitigate these risks

There were poor lone working practices with no lone working policy in place to keep staff safe

We identified safeguarding concerns during the inspection

Is the service effective?

Inadequate

The service was not effective

We found that staff did not consistently adhere to, or understand the principles of the Mental Capacity Act (2005) or implement this in their practice

Staff were not assessing people's needs and associated risks linked to their diagnosed mental health conditions

Is the service caring?

Inadequate

The service was not caring

The condition of the environment was not conducive to providing high standards of dignified care

People living at the service were not supported or encouraged to manage their personal hygiene or the overall condition of their living environment

Staff were not found to always treat people with kindness or respect

Is the service responsive?

Inadequate

The service was not responsive

People living at the service lacked access to meaningful activities and person-centred care

Staff did not respond effectively to risks or concerns, including those raised by us during the inspection visits

Is the service well-led?

Inadequate

The service was not well-led

We found poor governance arrangements in place

There was poor leadership and managerial oversight impacting on the safe running of the service

We identified concerns in relation to the management oversight of staff competency and their abilities to meet the requirements of their job roles

Quality checks and audits were not being completed by the management team, and this was reflected in our findings during the inspection

We identified incidents and concerns that the service had not notified CQC about

Service policies and procedures were found to be out of date and not reviewed. This included a new policy implemented at the request of CQC as an outcome of the first inspection visit

Holmwood

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 was an unannounced, comprehensive inspection, with visits completed on 26 November and 6 December 2018.

On the first day of inspection, the inspection team consisted of two CQC inspectors. On the second day of inspection, the team consisted of two CQC inspectors and one CQC medicines inspector.

Before the inspection, we received information of concern from external stakeholders. These concerns were reviewed as part of the inspection process. There had also been a recent incident resulting in the theft of medicines including controlled drugs from the service. We liaised with the Police service regarding this incident, and reviewed actions taken by the provider as an outcome during the inspection visits.

During the inspection we spoke with six people who lived at Holmwood. We observed care and support being delivered in communal areas and we also spoke with seven members of staff including the provider, acting manager, care staff, and ancillary staff. We spoke with one visiting healthcare professional. Due to the seriousness of concerns, we made referrals to Norfolk Fire and Rescue Service, the local authority safeguarding team and the local health authority infection prevention control team, after our first inspection visit.

We reviewed nine people's care plans in detail including their daily contemporaneous notes, weight monitoring, food and fluid charts where applicable. We looked at 13 people's medicine administration records (MAR) and the medicines management procedures in place. We attended the evening shift handover meeting on the first day of the inspection. We looked at three staff recruitment files as well as training, induction, supervision and appraisal records.

Inadequate

Is the service safe?

Our findings

During our inspection on 16 and 17 March 2017, we found the service was safe and was rated Good in this key question. This was because there were sufficient staff to meet people's needs. There was a positive and proactive approach taken in the management of risks to people. Medicines were managed safely and people received them as the prescriber intended.

During this current inspection, we found the care environment was unclean throughout the service, with significant environmental risks in relation to areas such as fire safety that were not well managed. We identified safeguarding concerns during the inspection and risks to people were not identified or measures put in place to reduce and mitigate those risks. We therefore rated safe as 'Inadequate.'

The service had poor cleanliness and furnishings throughout. We found communal living areas, bedrooms, bathrooms and toilets that had a strong malodour throughout both days of the inspection. We inspected each bedroom, and found people were living in very poor conditions, with damaged and stained bedding and carpets. Furniture within people's bedrooms was damaged. Mattresses were not protected where people experienced episodes of incontinence. Toilets and bathrooms were unsanitary. Repairs had not been completed where water leaks had occurred, resulting in some areas of the home smelling damp and musty, and some people's belongings being covered in a layer of what appeared to be mould.

People's care plans indicated the need for increased levels of support to manage their personal hygiene, particularly if experiencing changes in their mental health presentation. We found examples of unkempt bedrooms that staff were aware of, but had not intervened to support the person to address. Some bedrooms contained half eaten and decomposing items of food. One bedroom contained so many belongings, the person did not have a clear walkway to their bed. Electrical items were switched on within their belongings increasing fire risks.

We found stains and marks of what appeared to be urine and faeces in toilets and on equipment to assist people getting on and off the toilet. Cleaning records within these toilets and bathrooms were completed showing staff had signed to say they had cleaned these areas within 24 hours of the inspection visits. Some toilets did not have toilet paper or paper hand towels for people to use. One toilet did not have a toilet seat, and this remained missing at both our inspection visits.

The dining room was unclean, with grease and food debris on the floor and on surfaces. Table cloths did not cover the whole of each table. People did not have access to napkins and were not encouraged to wash their hands before eating. We observed that some people used their unwashed hands rather than cutlery to eat, increasing their risk of consuming germs from their hands. The provider had put hand wipes in place when we completed the second inspection visit.

People had access to hot drinks making equipment based in the communal lounge, cups were stained and the area was awash with spilt drinks and sugar. One person told us they preferred to ask staff members to make them a fresh drink from the kitchen rather than drink from the urns in place as they said the drinks did

not taste "horrible."

People's overall presentation was unkempt. Staff were observed to attempt to encourage people to access a bath or shower, the person would decline and staff were not observed to make further attempts. Some people were wearing the same, unclean clothing between our first and second inspection visits. Some people's finger nails were visibly unclean and black with dirt. One person's teeth were visibly unclean during our first visit. We raised our concerns regarding this with the manager. When we completed the second inspection visit 10 days later, we found that the person still had not cleaned their teeth as they did not have a tooth brush, and staff had not purchased one or assisted the person to source one once this issue had been identified. We asked people if they accessed showers regularly. One person told us, "I had a shower about three weeks ago, I strip wash the rest of the time." A second person who told us they experienced continence problems told us, "I strip wash regularly."

Many people were wearing stained and visibly unclean clothing. When we arrived on the first day, we identified that neither of the two washing machines were working. Soiled laundry was stacked four bags high, and precautions had not been taken by staff to store contaminated laundry separately. Staff told us one washing machine had not been working for many weeks. We were told the second one had stopped working two days before the inspection. No interim arrangements had been made to ensure people had access to clean clothes and linen. We checked the linen cupboard and found this did not contain clean bedding or towels, only blankets. One washing machine had been fixed by the end of the first day of the inspection, and both washing machines were in use when we completed the second day of the inspection.

Arrangements were in place for the storage of medicines in a dedicated medicine storage room. However, we noted that all members of staff could access this area and not only those authorised to handle and give people their medicines. Some people living at the service had their medicines given to them within the room, the service had not considered the risks around this. The cabinet used for the storage of controlled drugs (medicines needing special storage and recording arrangements) was not secured in line with Misuse of Drugs regulations. The service had recently reported to the police an alleged break in and theft of some people's medicines from the medicine storage room.

When we looked at people's medication records, we found there were discrepancies for the medicines, therefore staff could not account for all medicines. The corresponding records did not confirm people received their medicines as prescribed or what had happened to the medicines. We also noted that some medicines had not been promptly obtained and had not been available to give to people and to ensure they received their treatments continuously. This could have placed their health and welfare at risk.

Staff had not accurately transcribed some medicines onto people's medication records which did not provide us with assurances that people received their medicines and increased the risk that people could be given medicines that were no longer intended by their prescribers.

There were gaps in records for medicines prescribed for external use such as creams and ointments and we were unable to source assurances that they had been applied as prescribed.

Audits were in place to enable staff to monitor medicine administration and their records. However, we found these were ineffective at promptly identifying and resolving medicine issues.

We found that supporting information available for staff to refer to when handling and giving people, their medicines lacked detail and was inconsistent. For example, there was a lack of information about how people preferred to have their medicines given to them. Information about people's known allergies and

medicine sensitivities in notes and on medicine charts was sometimes inconsistent which could have led to error particularly when new medicines were prescribed.

Some people were prescribed medicines on an occasional when-required basis, to be given at the discretion of staff such as potentially sedative or addictive medicines prescribed to assist with people's psychological agitation. We identified that written information about their use lacked detail to show staff how and when to give this medicine to people consistently and appropriately. In addition, the information in place directed that these medicines should be given to people at their own request and not at the professional judgement of staff or in partnership with them. This did not provide us with assurances that staff effectively managed the use of when-required medicines to prevent excessive and inappropriate use. We found that records about these medicines showed people were given when-required medicines most days and often at their prescribed maximum limits.

Records inconsistently demonstrated that people living at the service received a review of their medicines by prescribers, and we noted that not all changes to medicines on the advice of prescribers was recorded by staff. We found examples of where a person was regularly not having their medicines given to them, and there were no records confirming that staff had referred this to the prescriber for advice and review of their medication.

For people prescribed skin patches there were additional charts to show they were applied to people's bodies in varying positions to reduce skin reactions and to confirm they were later removed before the next patch was applied. However, these records were not always completed by staff.

We identified staff with out of date medicines management training. One staff member was giving people medicines, but had not completed the provider's medicine training since starting in post approximately six weeks before the inspection. This risk was immediately escalated to the provider to address.

Up to date risk assessments were not in place for each person, in areas of care including the management of their mental health conditions, falls, pressure care and use of walking aids. The risk assessments that were in place did not reflect changes in people's abilities, recent incidents and changing levels of risk. Reviews of care plans were not inconsistently completed. Where reviews were recorded there was little or no information added. Sections of people's care records were colour coded in a traffic light system to reflect levels of risk presentation. We found sections contained multiple risk ratings making this unclear for staff to follow.

There was no one living at the service who used equipment such as hoists and slings, however staff told us one person was at risk when transferring from bed to chair due to fluctuation in their ability. Their care record stated they were 'bed bound', but daily records showed they transferred into a wheelchair to go outside. Their care records did not reflect if equipment options had been explored and their care records lacked clear guidance for staff to follow to mitigate these risks.

Staff were unfamiliar with people's current and historical risk presentations. This included people using or consuming items to harm themselves or inappropriate behaviours that could pose a risk to other people's safety including staff safety. We asked specific questions around people's risks with the manager, and the information provided did not correlate with details recorded in people's care records. This placed staff, other people living at the service and the inspection team at potential risk. We asked people if they felt safe living at the service. One person told us, "I feel frightened. One person keeps smashing things. They previously pushed me over." A second person told us, "I feel safe, but it is often very noisy here."

We found gaps in completion of contemporaneous, daily care notes. We were told by the manager these notes were filed on a monthly basis, therefore on the first day of the inspection, there should have been notes up to and including the 26 November 2018. For the care records examined, we found gaps of between 16 to 24 days, with the last entry in one person's records completed 02 November 2018. Risk incidents and indicators of changes in people's mental health presentation were inconsistently recorded and lacked details to indicate what action was taken by staff or outcomes from seeking specialist advice.

We identified a person living at the service that staff told us routinely barricaded themselves in their bedroom using their bed. This presented a risk to themselves and staff, particularly in the event of an emergency such as a fire. Adaptations to the environment had not been considered. Risk management plans and associated policies were not in place.

Personal emergency evacuation plans (PEEPS) were only in place for one person when we first visited. The service had given themselves a two-week deadline to get these documents in place, and had not thought about the serious management of risks in the interim. The manager agreed to have all PEEPS in place within 24 hours at our request. These were in place when we completed the second visit.

There were no designated smoking rooms within the service, but people were asked to smoke by the main entrance door or in an enclosed courtyard on the ground floor. We found examples of bedrooms that people were smoking in, and burn marks on windowsills and carpets in communal areas. Some people's care records highlighted historic fire safety risks as an area of concern. Many bedrooms contained cigarettes, lighters and lighter fuel. We found many fire safety doors were damaged or did not close properly. We were told in writing by the provider that 15-minute checks were in place to ensure those to be at known risk of smoking in their bedrooms would be prevented from doing so. When we spoke with the manager, and with staff during our second visit, those 15-minute checks were not in place, and we were told would only be implemented once a person was found to be smoking, rather than as a preventative measure.

Where people had been assessed to be at risk if having independent access to cigarette lighters, these were held by staff. However, we found the lighters were not stored securely, instead being housed on the top of a cabinet next to the staff office door, which did not prevent people's access to them. Where staff lit a cigarette for a person who did not have access to lighters, they did not remain with the person to ensure the cigarette was extinguished properly once finished. Our concerns regarding fire safety were reinforced when we observed a person who entered the service with a lit cigarette and discarded this onto the stairs carpet. Due to the level of concern identified, a referral was made to the fire and rescue service after the inspection. A full fire safety assessment was completed, and the fire service identified areas of risk needing immediate resolution by the provider. The provider was given a clear deadline for completion of works to address these risks. This was alongside additional risk management plans we requested for the provider to put in place within an agreed timescale.

We identified environmental risks not recognised by the service. Windows throughout the service, including on the first and second floors did not all have restrictors in place to keep people safe while having the windows open. The provider was given a deadline for window restrictors to be installed. The provider wrote to us to confirm all restrictors were in place mitigate identified risks. When we completed the second inspection visit, there continued to be windows without restrictors in place in parts of the service accessed by people.

We found exposed hot pipes and uncovered radiators that posed a serious risk of burns and scalds. The provider had not considered the increased risks this posed in relation to people with known history of harming themselves. The provider was given a deadline for all exposed pipes and radiators to be made safe.

The provider wrote to us to confirm all exposed pipes and uncovered radiators in areas accessed by people had been covered to make them safe. When we completed the second inspection visit, there continued to be exposed pipes and uncovered radiators in parts of the service accessed by people.

The service recorded completion of regular water temperature safety checks for hot water supplies but not for the coldwater system. Records were not kept for descaling of items such as shower heads. We identified episodes of the hot water readings being above 43 degrees, and there was not an escalation process in place if water temperatures were found to exceed safe temperatures. Water temperature readings in the kitchen were recorded as being up to 52 degrees. From our observations, the kitchen door was open with people going in and out of the kitchen throughout both days of the inspection, giving people access to unsafe water temperatures, as well as other risk items. The service had not considered or mitigated these risks.

The layout of the service and configuration of doors made it difficult for staff to monitor people throughout the building. This increased risk to the safety of staff and people living at the service, and there were no measures in place to mitigate those risks. The environment contained multiple ligature risks, which were not considered in relation to changes in people's mental health presentations, or as part of the service's environmental risk assessment documentation.

The above information meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From reviewing staffing rotas, and from conversations with staff there were insufficient numbers of staff on shift to meet the needs of the people living at the service. The provider told us staffing levels during the day were always set at four staff (one senior and three carers), with the manager covering staff breaks as needed. On the first day of the inspection, there were two staff on shift as the third carer was working in the kitchen as the chef had not arrived. The level of staff on shift during the day did not vary to reflect changes in people's support needs and mental health presentation.

At night time, there were two staff on shift. From examining rotas, this resulted in night staff working up to 14hour shifts. To enable night staff to take breaks, this resulted in times where only one staff member was on shift. For the level of complexity, oversight and monitoring required for the people living at the service, there were not sufficient staff on shift during the night. Consideration had not been given to the gender mix of staff on shift. In the care records for one person living at the service, it clearly stated that female staff were not to work in isolation with this person. From reviewing staffing rotas, we identified eight night shifts within a four-week period, where two female staff were on shift. There was a male and a female member of staff on the remaining night shifts, but consideration had not been given to the management of risks for sole female staff members when the other staff member took their breaks. We observed staff take their breaks outside the building in order to be able to smoke.

We identified that the service did not have a lone working policy in place. Staff did not wear personal alarms. Consideration had not been given to the layout of the care environment, or risks associated with people living at the service. We had received notifications, and other information regarding incidents where staff members had been assaulted by people living at the service. At our request, the provider was given a deadline for a lone working policy to be implemented. The provider wrote to us to confirm a working policy was in place. When we completed the second inspection visit, we reviewed the policy. This document was found to be out of date, and stipulated training the staff needed to have in place to keep them safe while working alone. This included fire safety and first aid. From reviewing training records, only two night staff had up to date fire safety training and two had first aid training, therefore a proportion of staff working on

night shifts would not have the training in place as stipulated by the provider's lone working policy.

The provider did not use a dependency tool to ensure there were sufficient staff on shift to meet people's needs, while recognising other risk factors such as the layout of the care environment. As an outcome of our first inspection visit, the provider was given a deadline for a review of staffing levels to be completed, and for a dependency tool to be implemented due to the level of risk identified. The provider wrote to us to confirm staffing levels had been reviewed and a dependency tool completed. When we completed the follow up inspection visit, the staffing levels remained the same as at our initial visit, and we found the dependency tool had not been completed to accurately reflect the level of dependency of people living at the service.

We identified differences in data provided by the service for completion rates for training and refresher courses, stipulated as mandatory by the provider. Not all staff had received training in medicine management, where this was a requirement of their job role. There was no specialist training in place in relation to mental health conditions or the Mental Health Act (1983). We could not be assured that staff had sufficient training and competency checks in place to ensure they met the requirements of their job roles.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From examining staff employment records, concerns were identified in relation to Disclosure and Barring Service (DBS) checks which indicated for two out of the three records checked, that their DBS was 'issued within the last six months of employment with their last employer'. We could not source assurances that the provider was routinely completing a new DBS application or the relevant checks when a staff member started in post, in line with DBS guidance. (DBS checks helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups undertaken before new staff started work).

We identified a recently dismissed member of staff, who the provider expressed concerns about regarding their performance and competence as a manager. The provider told us they sourced managers through a recruitment agency. They raised concerns about the quality and skills of the last two managers they had appointed. The provider was not taking accountability for their own role and responsibilities within the recruitment process. We were told that a director for quality visited regularly to monitor the performance of new managers, yet concerns regarding the performance of the last manager were not rectified until an external quality audit was completed by third party stakeholders.

Two staff members had resigned following a serious incident, we asked the provider what action they had taken as an outcome. Initially they told us that they had taken formal disciplinary action. We requested to see a copy of the disciplinary paperwork, the provider told us the two staff members had resigned before formal disciplinary action could be taken. We asked if concerns regarding their performance had been reported to the DBS. This had not been completed by the provider. Following the inspection, the service confirmed in writing that they had sourced legal advice around their responsibilities for sharing information with DBS.

The above information meant the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an up to date legionella water safety certificate. The service had electrical and gas safety certificates in place. For those people who had equipment, such as electric profiling beds, an external company was responsible for completing maintenance checks.

Inadequate

Is the service effective?

Our findings

During our inspection on 16 and 17 March 2017, we found the service was effective and was rated Good in this key question. This was because staff and the registered manager understood their responsibilities in relation to the Mental Capacity Act (MCA). People were supported to maintain their health and manage their nutritional needs.

During this current inspection, we found that staff did not adhere to, or implement the principles of the Mental Capacity Act in their practice. Staff were not assessing people's needs and associated risks linked to their diagnosed mental health conditions. We have therefore rated effective as inadequate.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. No-one living at the service were subject to DoLS.

Care records did not contain mental capacity assessments that were time, date, question and decision specific. We identified examples of where we would expect to see completion of capacity assessments, for example a person who had not had their ability to manage their finances assessed, and their care record identified they regularly withdrew large sums of money and spent the money unwisely. Another example related to those people found to smoke inside the service and where staff restricted people's access to cigarette lighters. Consideration had not been given to whether these people had insight into risks to themselves and others,

Four people living at the service were subject to aspects of their community aftercare being provided under or linked to the Mental Health Act (1983). Where people were not consenting to have treatment such as depot injections (slow release, long lasting medicine injected into the body), or experienced non-compliance with their medicines we were unable to find evidence that such concerns had consistently been escalated to their community mental health teams or management plans implemented to ensure staff were aware of risks and implications not having their medicine could have on their mental health and wellbeing. Staff were not recording whether people's capacity was being assessed to determine their insight and understanding into the implications of non-compliance.

The provider was planning to install closed circuit television (CCTV) in and outside the service. People living at the service had not been consulted. Consideration had not been given to people's capacity to agree to the use of CCTV or the potential impact this could have on their privacy, dignity and human rights.

Staff were not consistently able to explain the principles of the MCA and DoLS and how this would be implemented in the care and support they provided to people living at the service, this was reflected by the fact only seven out of eighteen staff had completed MCA and DoLS training. Staff, including the manager confused the principles of the MCA with the Mental Health Act (1983), to the extent that we were repeatedly told a person was going to have an assessment of their capacity by a healthcare professional. This turned out to be a Mental Health Act (1983) assessment.

The above information meant the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested, in writing, information from the provider to confirm that staff had up to date annual performance appraisals in place, this evidence was not provided. Records showed a lack of supervision being provided for staff. Supervision offers staff the opportunity to discuss their work, receive feedback on their practice and identify training and development needs. Audits completed by the director of quality for the service identified shortfalls in staff supervision in June 2018, yet regular supervision sessions were still not in place when we inspected in November 2018. This was not in line with the service's statement of purpose that stated, "There is regular monthly supervision for all staff including appraisals."

Training figures indicated that staff were not up to date with completing the provider's mandatory training including role specific courses. The service accessed training through on line and face to face sessions. Completion rates were low, staff practice and approach did not demonstrate that training and associated competencies were implemented into the care and support provided. This was not in line with the service's statement of purpose that stated, "To maintain quality service delivery to our residents, management are constantly carrying out staff training needs analysis and organising refresher courses to ensure appropriate training is provided." Staff told us they had a deadline to complete all online training courses, but staff training was not up to date at the time of the inspection visits.

We attended the evening shift handover meeting on the first day of inspection. The level of detail discussed was poor, and did not provide a thorough overview of risks and concerns. This did not provide sufficient detail to be able to care for people or to be aware of reviews in relation to risks and incidents from the last 24 hours. The manager told us that staff completed written shift handover records, and this information was available if a staff member was late. We reviewed the shift handover records, and found these were not completed twice a day for each shift handover, and there were only four records on file for November 2018. Some of the language used in the records was unprofessional, for example referring to a person 'winding people up.' During the shift handover meeting, staff made statements such as, "shouting at times, usual for [name]." Staff knowledge and understanding of people's presentation lacked insight, and related to the lack of specialist mental health training provided.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people living at the service were able to eat and drink independently. People had access to insulated hot water urns to make drinks independently, and we observed some people going to the kitchen and asking for drinks, or having jugs of squash made up for their bedrooms. Risk assessments had not been put in place around the potential environmental risks of people having access to boiling water, or the fact we

observed a lot of spilt drinks which could pose a slipping hazard to people using the service and staff.

Staff were unclear around the management of specialist diets and use of calorie build up drinks. We observed one person who was visually impaired, placing large pieces of meat straight into their mouth which increased their risk of choking or burning their mouth and hands. This person's care record listed for them to have a soft diet due to a lack of teeth, yet we observed them eating a whole piece of meat and vegetables that were the same size and consistency as everyone else was eating.

From the records examined, staff were not always recording when people had consumed build up drinks or if these had been offered and declined. Every person was weighed monthly, rather than any form of tailored plan linked to risks and changes in presentation. Some people's care records gave examples of where changes in people's food and fluid intake was linked to their mental health presentation, these risks were not well recognised or managed.

We observed the lunchtime meal on the first day of the inspection. The environment was noisy and chaotic. Some people waited a long time for their meals, and became frustrated. We observed some people to get up and leave rather than wait to eat. Pudding started to be served before everyone had finished their main meal. There were no drinks on the table. There was only one meal choice. When we spoke to the staff members in the kitchen in the morning, they were unable to advise what the pudding was going to be as they were waiting for a food delivery. This resulted in the menu being inaccurate for people to check.

Staff did not engage with people during the meal time, and due to a food delivery arriving while lunch was being served, staff were diverted to unpack and put away the delivery. This resulted in no staff observing the meal time to monitor people's food intake levels or potential choking risks.

We observed two people attempting to source reassurance from staff during the mealtime. One person asked for reassurance, the staff member did not respond and walked away. One person held onto the sleeve of a staff member, the staff member did not react, instead speaking with a colleague rather than turning around to speak with the person or to ask them to let go of their sleeve.

Staff told us that one person needed to be assisted to eat their meal to prevent them from placing large amounts of food into their mouth. Consideration had not been given to the person's dignity, and if there were alternative ways of approaching this for example, for a staff member to sit with them and monitor the level of food they were placing in their mouth, or for the person to be given their meal in smaller amounts. We observed the staff member carrying this person's plate to the table and they spilt some of the gravy on the floor. Overall, there was a lack of care taken to ensure people had an enjoyable dining experience.

Some people's food and fluid intake was recorded on monitoring charts. We reviewed these and found they contained many gaps in information. There were no target levels to ensure staff knew when to escalate concerns if a person's intake dropped. Fluid intake was recorded as a tally chart, rather than amounts for example fluid intake by cup sizes. There was no section on the form to show action taken by staff where someone's intake was repeatedly poor, or concerns were identified. Some people were meant to eat snacks in addition to their meals to increase calorie intake across the day, provision of snacks was not consistently recorded on the monitoring charts. Some records had food or fluid listed, with arrows next to them. It was therefore unclear when the food and fluid had been given, and whether it had been consumed. This was of particular concern for people who did not access the dining room for their meals, instead eating in their bedrooms. Records did not demonstrate that these people had received their meals at consistent times.

People's food and fluid intake over 12 to 24hour periods was not discussed or reviewed during shift

handover meetings, or recorded on the shift handover records available for us to review during the inspection. Not all staff had up to date training in food hygiene. For nutrition training, only two staff members had up to date training and these were not staff members who were employed to work in the kitchen. This did not offer us assurances that staff had sufficient training and skills to recognise and understand how to meet risks associated with people's nutrition and hydration needs.

Staff did not record the date when people were weighed, and we could not be assured that changes in weight were monitored closely and linked to the Malnutrition Universal Screening Tool (MUST), used to identify people, who were at risk of not maintaining a healthy weight. We identified examples of where the MUST score had been calculated incorrectly, resulting in changes in their weight and associated risks not being accurately reflected.

From reviewing the service's nutritional policy, this did not provide guidance for staff on how frequently people should be weighed, or in the use of food supplements to aid calorie intake. We found examples of people declining to be weighed each month, records did not reflect that further attempts had been made to ensure their weight was being monitored.

The above information meant the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us the service had a criteria for admissions, and that they would complete a pre-admission assessment and that people usually moved into the service on a trial basis, with consideration against the needs of existing people living at the service. The manager told us they offered places for people needing rehabilitation, for example, to increase their skills and confidence to enable them to move onto living independently. The service did not work to a rehabilitation model, staff were not trained in provision of rehabilitation and care plans did not contain clear goals for people to work towards.

People using the service and staff told us they had good relationships with two local GP surgeries, and members of the community nursing team visited the service daily to support people with diabetes care. However, we identified that information and guidance from healthcare professionals was not consistently detailed or linked to people's risk assessments and care plans. We also identified examples of people living with conditions such as diabetes, whose care records did not record the need for regular access to chiropody and foot care services.

Due to gaps in people's daily care records, we found examples of where an incident such as a fall had occurred, a GP appointment was booked, but the outcomes of the appointment and any follow up were not recorded. We were unable to source assurances that staff were consistently following medical advice when sourced.

The manager told us about one person who they described as not wishing to engage with GP appointments. We reviewed their care plans and risk assessments, and these did not contain reference to difficulties encouraging the person to engage with medical appointments, or strategies in place to ensure the person's medical needs were appropriately met.

We spoke to people about accessing medical appointments. One person told us, "I go to the GP surgery for appointments as needed."

Inadequate

Is the service caring?

Our findings

During our inspection on 16 and 17 March 2017, we found the service was caring and was rated Good in this key question. This was because people were supported by kind and caring staff who encouraged their independence. Staff listened to people and they were able to discuss their care needs.

During this current inspection, we found the condition of the environment was not conducive to high standards of dignified care. People living at the service were not supported to manage their personal hygiene and levels of personal appearance. People were not consistently treated with respect and compassion. We therefore rated caring as inadequate.

Some people living at the service required high levels of staff support linked to changes in their mental health presentation. The condition of people's bedrooms and communal facilities such as bathrooms and toilets smelt unpleasant and were visibly unclean. Staff were not encouraging people living at the service to maintain their personal hygiene, appearance or to take pride and ownership of the condition of the overall service.

We identified examples of people living at the service who experienced episodes of self-neglect in relation to the management of their personal hygiene, and care for their skin, nails and teeth. The condition of the home and lack of basic resources such as toilet paper, hand towels and linen did not encourage or support people to use facilities within the care environment.

We observed staff missing opportunities to interact with people or being cold in their manor towards people. Some people experienced behaviours which may challenge others, and staff lacked the training and skills to interact with these people to offer meaningful support. We noted that some staff found certain people living at the service challenging to work with, and kept their interactions with them to a minimum. The management team had not recognised this as an area of risk, or the potential impact this could have on people's care and the support provided.

People's care records contained limited or no life history information, staff were not always recording people's personal preferences, including their likes and dislikes, interests and hobbies. One person's care record listed that they had no family. When we spent time with that person, and spoke to them, they listed off family members and where they lived. From our observations and reviews of care records, we were unable to source assurances that staff spent quality time interacting with people to get to know them.

Community meetings were held for people living at the service to attend. These meetings did not have a set agenda, and from minutes examined they mainly covered meal choices and complaints about people smoking inside the service rather than in the designated areas. We noted an example where a person had said they would like to have treacle pudding, but for this to be considered an option to be put on the menu, it required agreement from everyone present at the meeting for the request to be accepted, rather than offering people individual choice. Complaints and concerns about the service were not consistently discussed as an agenda item. People living at the service were not encouraged to give feedback or

contribute to the running of the service. From information provided by the service, the management team did not complete satisfaction questionnaires with people, staff or relatives to source feedback on the standards of care provided or ways of improving the service.

In a person's care record, we found evidence of guidance telling staff to withhold the person's cigarettes until they had accepted their daily medicines. This reflected the lack of skills and expertise within the staff group to find more appropriate methods of encouraging compliance with medicines. We could not find justification for this blanket restrictive practice being in place, and staff were not adhering to The Mental Health (1983) Act Code of Practice or principles of the Mental Capacity Act (2005).

Care records did not demonstrate collaboration between staff and people living at the service in their development. Staff were not advocating for people or empowering them to be independent and involved in their own care and mental health treatment. Many of the care records were only signed on completion by a member of staff, and did not record if the person had declined to sign it or be involved in the care planning process.

The service consisted mainly of male people, with a variation on age range. Consideration had not been given to whether some people would find spending meal times, in one large room noisy and stressful. Consideration had not been given to the gender mix of people living at the service, and whether rooms or areas of the service needed to be designated as quiet areas or any associated risks. There was a strong smell of cigarette smoke throughout the service, impacting on the condition of people's bedrooms and living environments particularly for those people who did not smoke.

Some people's behavioural presentations were exhibited in front of others living at the service. Staff did not actively take steps to protect those people's privacy and dignity. Staff had not carefully considered the impact this had on other people living at the service. We observed episodes of hostility and exchanges of unkind words between people living at the service, and staff were not seen to interject or encourage people to treat each other with respect or kindness.

The above information meant the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

During our inspection on 16 and 17 March 2017, we found the service was responsive and was rated Good in this key question. This was because people received responsive care that was individual to their needs and preferences. This included the provision of activities. There were opportunities for people to raise concerns and complaints which were responded to.

During this current inspection, we found that people living at the service lacked access to meaningful activities and person-centred care. Staff did not respond effectively to risks and concerns. People were not supported and encouraged to make complaints or provide feedback on the service. Therefore, we therefore rated responsive as Inadequate.

The service had received six complaints during 2018. The statement of purpose for the service included guidance on the management and response to complaints, and in relation to offering people the opportunity to raise concerns. This asked for concerns to be shared with the manager, "who will investigate the matter discretely and report back to you within seven days." The information relating to outcomes of complaints did not demonstrate if people's concerns had been addressed. Complaint investigations were not consistently discussed during staff meetings based on meeting minutes reviewed as a means of learning from feedback received.

We asked people how they would raise concerns or make complaints. One person told us, "I would speak to the manager if needed."

Staff did not write care plans collaboratively with people and their relatives, (where appropriate). Plans were not person-centred or holistic incorporating areas of personal importance. Care records were not regularly reviewed and updated, and did not incorporate people's personal preferences. Care plans were not consistently linked to risk assessments, and did not contain guidance for staff to follow in relation to the management of people's mental health conditions. Care records did not contain protective factors or crisis plans with people's future wishes set out to guide staff on how the person wished to be treated if they became unwell and were unable to express their preferences independently.

The overall condition of the environment impacted on access to clean and safe bathing facilities for people living at the service. Environmental limitations impacted on access to bathing facilities for those people living with physical support needs and disabilities. The bedrooms and bathrooms were across four floors, with steps and stairs in between floors. The people carrying lift was not working, resulting in people living at the service and staff needing to go up and down steep flights of stairs. We found some loose steps while inspecting the service. Environmental conditions and equipment limitations, along with staff skills and training impacted on their ability to offer personalised care and support. The provider had not put measures in place to manage and mitigate those risks.

Care records did not contain details of the level of support provided where a person could not meet their care needs independently. We found examples of people's care records that stated that people did not wish

to engage with staff in the management of their personal hygiene, and were known not to complete tasks themselves. The lack of support to maintain basis standards of personal hygiene was reflected in the condition of people's overall appearance, including with oral hygiene, foot care and skin integrity. Some people, whose care records showed they neglected their personal hygiene, were also experiencing issues with their continence, increasing their risk of developing sore and damaged skin.

Risk ratings on people's care records were inconsistent, increasing the risk that staff were not aware of current levels or responding proportionately to incidents and concerns. From reviewing incidents, we could see that staff were not updating people's care records and associated risk assessments to reflect changes in presentation. This was placing people living at the service and staff at risk. This also resulted in a lack of detailed information to share with healthcare professionals when trying to support the need for a person to be moved to a more suitable care setting, or to support an increase in daily levels of support.

We found an example of where care records set out management plans to support a person experiencing episodes of unsettled behaviour. The records set out the need for the person to receive daily activities and have weekly meetings with staff. Daily care records, staffing and activity levels at the service did not offer this person the level of support, daily monitoring and oversight to meet their needs in line with their care plan.

The manager told us that no one living at the service was at risk of harming themselves for example using sharp objects. Yet from reviewing people's care records, these highlighted examples of people at risk of harming themselves with sharp objects and items of electrical equipment. The care records stipulated for staff to regularly check electrical equipment to ensure this was not damaged and to prevent risk of inappropriate use. The provider was unable to produce written evidence to demonstrate these checks were being completed. From walking around the service, we found risk items that had not been identified or addressed by staff or the management team.

People's level of involvement with the local community was linked to whether they could access the community independently, as there were insufficient numbers of staff to assist people to go off site with support. Some people's care funding included access to community based activities and day services. People were not involved in decisions relating to the running of the home. There was not a daily activity timetable. We observed people sitting watching television and smoking throughout both days of the inspection. A small group of people had been food shopping, and some people sang on a karaoke machine on the first day of the inspection.

We asked people living at the service about the activities available. One person told us, "I would like there to be more activities here." A second person told us, "I would like more activities, it is a very long day, I get bored. I do sometimes help take cups to the kitchen."

People lacked stimulation, meaningful activity and structure to their daily routine. The Mental Health Act (1983), Code of Practice sets out the importance that services 'promote recovery after a person leaves hospital, including opportunities for meaningful daytime activity and employment opportunities.' The service was not working to a mental health recovery model to support people to progress onto living independently with the possibility of moving on from the service to living in the community.

Care records did not routinely document that incidents and concerns had been escalated by staff to community mental health teams and other professionals. Where guidance had been sourced, records did not consistently demonstrate implementation into practice. Staff were not working collaboratively with community professionals to share management of risks or detailing guidance received into management plans.

For people receiving care while in bed, we identified that suitable equipment had not been put in place to maintain their safety or allow for variability in their abilities. No one had access to call bells in their bedrooms or in communal areas. This resulted in people being unable to source assistance when required. From reviewing care records, we identified an incident where a person had found another person unwell during the night and had needed to source staff assistance on their behalf. We asked people how they would source assistance, particularly at night time. One person told us, "I would call out if I needed help during the night. There are no call buttons in the bedrooms."

We received very unclear information from staff and the manager as to how frequently people should be checked during the day and overnight, to make sure they were alright, and to account for each person under the care of the service. The manager told us that welfare checks should be recorded in people's care records, but this information was inconsistently recorded, and lacked details around the timing and frequency of the checks being completed. Some people's care records stated that they required night time checks, but did not list how frequently, or the reasons why this was felt by staff to be required. We found hourly observation sheets for staff to use, but these were blank and not in use by staff.

Due to the low number of staff on shift, and layout of the service across four floors, we were concerned that staff were not able to provide the level of monitoring and oversight of people, particularly overnight. There had been a recent medicine theft that the service had notified CQC about. This incident happened at night, and from speaking with the provider, we were told the night staff had not responded to the noises as they thought this was a person banging their door. We were concerned that in response to this incident, the provider had not taken steps to improve the overall security of the service for the safety of people living there and staff. We were unable to source assurances that the service was implementing change and learning lessons in response to incidents.

From the care records examined, there was a lack of clarity in relation to people's preferences around the care they wished to receive at the end of their life. There were no end of life care plans or evidence of discussions between people living at the service and staff recorded for each set of care records we examined. Where end of life care plans were in place, these contained limited details. Where people experienced the death of friends or other people living at the service, staff lacked the skills and training to offer support and debriefing. This was important to assist people and staff with the management of their own emotional well-being.

The above information meant the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

During our inspection on 16 and 17 March 2017, we found the service was well-led and was rated Good in this key question. This was because the quality of the service was monitored. The management team took action to make improvements where required, including effective networking to benefit the service. There was an inclusive and positive atmosphere in the service. Staff spoke positively of the registered manager's leadership and the improvements that had taken place in the service.

During this current inspection, we found poor leadership and managerial oversight impacting on the safe running of the service, with poor governance arrangements in place. We therefore rated well-led as inadequate.

The service did not complete quality audits. The management team did not complete and document spot checks during the night to monitor standards of service provision. Checks completed of the care environment by the management team were not to a high standard, and this was reflected by the condition and concerns relating to the environment identified during the inspection.

The management team gave us a copy of their environmental audit completed in November 2018. The audit did not contain action points to be completed, and had not identified the extremely serious condition of the care environment. The provider told us they planned to refurbish the service, however anticipated this would take nine months to complete, there was no recognition of the urgency to improve living conditions for people at the service.

The director of quality completed six monthly service audits. We identified that action points from the audit completed in January 2018 had been rolled over to the June 2018 audit, with unclear timescales and action points stating to be completed "asap." The lack of managerial scrutiny resulted in an overall lack of improvement within the service, with no one taking accountability for ensuring issues were addressed.

There were no checks by the management team to monitor the quality of recording of contemporaneous daily care notes and monitoring forms such as food and fluid charts. We identified that one staff member on each shift was responsible for writing daily notes and completing care records for the whole shift. This resulted in staff members completing tasks but not being responsible or accountable for recording their completion. This increased the risk of inaccuracies. Concerns regarding the quality of recording in daily records was identified by the quality director in the six-monthly service audit completed January 2018, yet remained an area of poor practice when we inspected in November 2018.

We identified examples of poor medicine management processes in place. We spent time observing staff members giving people medicines. The telephone constantly rang increasing their risk of distractions. Due to there being no people carrying lift staff were unable to take a medicine trolley between floors in the building. The standard of competency checks completed was poor, with a lack of managerial oversight. An external pharmacy audit had been completed, with a detailed action plan provided. The management team had not ensured that the points from this action plan had been implemented into practice.

As an outcome of our first inspection visit, some people's care records had been updated, but when we completed the second inspection visit, these documents had not been printed out. The staff therefore continued to only have access to the out of date version of information. When we asked to see the updated care records, the management team took many hours to provide this information, and did not have sufficient paper to print out the records.

Service policies were out of date. This did not safeguard staff or people living at the service. This also highlighted a lack of provider level oversight of the running of the service.

Environmental risk assessments were not thorough, they did not reflect our findings and the risks identified during the inspection, and were not linked to the individual needs and risks of those people living at the service. Where we identified significant risks needing to be urgently addressed, we wrote to the provider, but action was not taken to address the risks within agreed timescales. This did not provide assurances that the provider recognised the seriousness of our concerns or the risks posed to people living at the service.

From reviewing fire safety audits completed by the fire service in 2017, many of the areas of environmental concern remained unaddressed when we completed our inspection visit. The provider did not recognise their accountability for acting on guidance issued by the fire service to ensure the safety of all people living at the service.

We identified that there had been shortfalls in the performance of the last manager, and this had not been identified by the provider or director of quality until a third party stakeholder audit was completed. The service had not had a registered manager in post since December 2017 and the service was on its third unregistered manager since March 2018. At the time of the inspection, the deputy manager was acting as the manager on a temporary basis, with a replacement manager due to start in post January 2019. Experienced, and consistent leadership was required to drive improvement and aid service stability.

The management team did not use a dependency tool to ensure they had sufficient staff on shift during the day and overnight. Between our first and second inspection visits, a dependency tool was implemented at our written request, but this was found to be inaccurately completed. This did not offer us assurances that the provider recognised the level of risk associated with insufficient numbers of staff being on shift.

We identified concerns regarding adherence to safe employment and HR processes, this placed people living at the service and staff at risk.

The management team were not monitoring that mandatory training was up to date, or that new staff had completed all relevant training to meet the requirements of their roles. The management team lacked insight into the importance of assessing staff competence to implement training into the care and support provided.

We gave the management team a written list of information we needed to access, and a timeframe for this information to be made available. On both visits, the management team did not provide all the information requested or within the agreed timescales. The management team did not have organised systems in place for the management of information relating to people and the running of the service.

Approximately two weeks before our inspection visit, a full quality audit had been completed by a third-party stakeholder. From concerns received, many of the risks and issues identified during this inspection had already been brought to the provider's attention. It is therefore extremely concerning that little action had been taken or plans put in place to mitigate and manage these risks, and that further areas of serious

concern were identified during our inspection visits.

The above information meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed incident forms, but these did not consistently contain a record of onward referrals made and there was no reference to lessons learn or dissemination of information to staff as outcomes from incident investigations, by the manager. We identified examples of incidents that had not been notified to CQC.

The above information meant the provider was in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Due to the level of risk identified from this inspection, we wrote to the provider under Section 31 of the Health and Social Care Act 2008, to request for provision of an action plan to address our concerns. The action plan received did not contain adequate timescales to address and mitigate the risks identified. This did not offer us assurances that the provider recognised or understood the concerns identified.

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 18 Registration Regulations 2009 Notifications of other incidents The care provider had not ensured incidents and safeguarding concerns had been routinely notified to CQC. Registration regulation 18: (1) (2) (e) (g) (iv)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and support records were not person-centred. Environmental limitations impacted on people's access to essential facilities. People were not offered choice and control over their daily routine. People did not have access to meaningful activities. The care provider was not promoting mental health recovery and improvement. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) (h) (5) (6)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect

People were not always supported to maintain their privacy and dignity.
The care provider was not working in line with the principles of the MHA (1983) Code of Practice or MCA (2005) with blanket restrictive practices in place.
People were not encouraged to live independently or autonomously.

Regulation 10 (1) (2) (a) (b) (c)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not always providing care and support to people within the principles of the Mental Capacity Act (2005). Regulation 11 (1) (2) (3) (4) (5)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider did not ensure the service was kept clean and in line with infection, prevention and control practices. People were not supported to maintain their safety. Risks to people were not well managed or mitigated. Significant fire safety concerns were identified. Regulation 12 (1) (2) (a) (b) (d) (e) (f) (g) (h)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The care provider was not accurately monitoring people's food and fluid intake where risks had been identified. Regulation 14 (1) (2) (a) (I) (ii) (b) (4) (a)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance processes and procedures in place. Audits and quality checks were not being completed to monitor and mitigate risks and areas of poor practice. Shift handover meetings did not ensure all risks and concerns relating to people were handed over and discussed. The care provider did not have good leadership and management in place. The care provided did not ensure people's care records were kept up to date or contained the required level of detail relating to risk and care needs. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The care provider did not have effective recruitment processes in place, with gaps in completion of pre-employment safety checks. The care provider did not report concerns regarding staff member's practice or clinical

competence (where applicable) to the relevant regulator professional bodies.

Regulation 19 (1) (a) (b) (2) (a) (3) (a) (b) (4) (a) (b) (5) (a) (b)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to be responsive to risks and meet people's needs. Staff had not got the skills and training needed to meet the requirements of their roles. Staff did not access regular supervision, their performance was not monitored. Regulation 18 (1) (a)

The enforcement action we took:

As a result of our serious concerns about people's safety CQC used its urgent powers to remove this location from the provider's registration. This decision was subsequently ratified by a first tier tribunal judge.