Reside Care Homes Limited

Reside at Southwood

Inspection report

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25 January 2018
30 January 2018
28 February 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive inspection took place on 16, 17, 25 and 30 January 2018 and 28 February 2018. The visits on 16 and 30 January and 28 February were unannounced. We let the provider know we would be visiting on 17 and 25 January 2018 so that senior staff would be available to speak with us, and appropriate records would be available. The visit on 30 January 2018 commenced at 6.30am to enable us to meet with night staff.

At our last inspection in September 2015 we found the service was running well and rated it as good.

Reside at Southwood is a 'care home'. 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. The home is registered to accommodate a maximum of 38 people who require support with personal care. There were 34 people living in the home at the start of our inspection.

The home comprises three individual houses which have been linked together to form one building. Accommodation is provided in individual bedrooms on the ground, first and second floors. Some rooms have ensuite facilities. There are two lounges and a dining room on the ground floor. The home specialises in providing care to people living with dementia.

The service was led by a registered manager. 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. During the course of the inspection, the registered provider advised CQC that the registered manager had ceased working at the home and the operations manager had taken over interim responsibility for the service until a new manager could be recruited.

The feedback we received from people and their relatives and visitors was that staff were kind and they were happy living at Reside at Southwood. Not all of the staff made meaningful connections with people and therefore not everyone received person centred care. This was because many of the staff focussed on completing a task and then moving to the next task.

Systems and procedures to ensure people were safe in the event of an emergency were not effective. Proper drills had not been carried out to allow staff to practice how they would evacuate people and there was not enough equipment to help them do this.

Staff numbers and skills were not always adequate to meet people's needs. We raised concerns about the number of staff on duty at night and found that not all staff had completed basic training that is recommended before they care for people unsupervised.

Systems to manage the administration of medicines were not robust and meant that people may not always be receiving their medicines as prescribed. We could not be sure that people always received all of the food and fluids they needed to maintain good health.

Systems to manage risk and ensure people were cared for in a safe way were ineffective. Risk assessments were not always fully completed or regularly reviewed. Some risks had not been identified and therefore no action had been taken to reduce or manage the risk. For example, a person had an accident involving a piece of furniture. No action was taken to prevent it recurring and the person later sustained a serious injury in another accident with the same piece of furniture. The service had not carried out risk assessments to ensure that the equipment was fitted correctly and worked safely. This meant that people's safety and well-being was not always protected.

People did not always have their rights protected because the service did not operate in accordance with the Mental Capacity Act. For example, people did not have free access to their bedrooms whenever they wished to.

Care planning systems were not robust. Some assessments had not recognised specific care needs and no care plans had been created for these. Some people's needs had changed and care plans had not been reviewed and amended. This meant that staff may not be aware of people's needs and therefore people may not receive they care they required.

Management arrangements and systems did not ensure that the service was well-led. Recruitment procedures were not always followed and therefore the service could not demonstrate that some staff were suitable to work with vulnerable people. Quality monitoring systems were not used effectively and record keeping was poor, as records were out of date and contained errors and omissions.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Systems for the management of medicines were unsafe and did not fully protect people.

Care was not always planned and delivered in a way which protected people from the risk of harm.

We identified concerns regarding staffing levels at night. There was limited evidence of the satisfactory conduct or good character of staff in their previous employment.

Is the service effective?

Inadequate

The service was not effective.

Some people had lost weight and may not always have received appropriate food and drink or been supported to eat and drink enough to meet their needs.

Staff had not always received the training, supervision and support they needed.

People's rights were not always protected because the service was not acting in accordance with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

Improvements were needed in the way care was provided to people.

Staff did not always support people in a person centred manner and their privacy and dignity was not always promoted and protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of receiving unsafe care because their care plans were not up to date and detailed. Changes in needs were

not always reassessed and planned for and contradictory instructions were not identified and questioned.

The service had a complaints policy and complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider was not meeting their responsibilities to manage the service under the Health and Social Care Act 2008. There were multiple breaches of regulations.

Action had not been taken to assess, monitor and mitigate the risks to people living at the home.

Quality monitoring systems were ineffective and record keeping required improvement.

Reside at Southwood

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 comprehensive inspection took place on 16, 17, 25 and 30 January 2018 and 28 February 2018. The visits on 16 and 30 January and 28 February 2018 were unannounced. The visit on 30 January 2018 commenced at 6.30am to enable us to meet with night staff.

The inspection was carried out by an adult social care inspector and an assistant inspector was present for each day except 17 January 2018.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury.

The information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

The provider had completed a Provider Information Return (PIR), which we reviewed. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all the other information we held about the service, including previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We also contacted the local authority commissioners and safeguarding team to establish their views of the service.

We met and spoke with 12 of the people living in the home. Because a large proportion of the people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three visiting relatives or friends, the operations manager, the registered manager, eight

members of staff and two visiting health or social care professionals.

We observed how people were supported and looked at 15 people's care and support records and records and documents about how the service was managed. This included nine staffing records, audits, meeting minutes, training records, maintenance records and quality assurance records.

Inadequate

Is the service safe?

Our findings

Everyone living at Reside at Southwood was living with some degree of dementia and most people were unable to tell us whether they felt safe. We observed that, where this was the case, they responded positively when staff approached them, they smiled and responded positively to staff when they were approached. Other people told us that they were comfortable. However, we found shortfalls regarding the management of medicines, the identification and management of risk, fire precautions, the condition of premises and furnishings, staff recruitment practice, staffing levels and training which may place people at risk of harm.

During our inspection we identified concerns about the staffing, management of the home and emergency arrangements at night. The fourth day of our inspection was unannounced and commenced at 6.30 am so that we could meet the night staff and look at how the staff were deployed. There were three staff on duty to care for 32 people in the home.

The home consists of three houses joined together: the first and third houses have accommodation on the ground, first and second floors. The second and third houses are joined together on the ground and first floors. The first house can only be accessed from the ground floor. This means people living in the home are spread out over a large area. If staff were attending a person on the first or second floor of the first house and another person required support in the third house on the first or second floor, staff would have to walk to the ground floor and through the second house.

Many of the people living in the home also needed two staff to support them safely especially those people who required support with mobilising. The registered manager confirmed that 10 people were reliant on being hoisted and then used wheelchairs for all transfers from their beds or armchairs wherever they were in the home. Staff also told us that many other people were only able to walk a very short distance with Zimmer frames, other mobility equipment and staff support and would probably need a wheelchair to evacuate the home depending on the time of day and how they were on the day in question. Staff told us that it was unlikely that any of the residents would understand the fire alarm and evacuate the building without support from staff.

Only one of the three night staff on duty during our visit had completed fire training. The other two staff were new to care, had been employed at the home since February and March 2017 and had not completed full fire training. They had completed a very basic induction to orientate them to the home, fire escape routes and firefighting equipment but not the required full training. There were seven other staff on the rota, both during the day and night, who had not received fire training.

A requirement of the Regulatory Reform (Fire Safety) Order 2005 is that services such as Reside at Southwood should have a plan in place to ensure that they can evacuate people from danger within a specified period of time. Evacuations are the responsibility of the provider and not the fire service who will be primarily responsible for tackling the fire. We asked two of the night staff what they would do in the event of a fire. They agreed that they would check the fire panel and one person would then go to the zone indicated. If there was a fire the person in charge would call the fire brigade. After prompting, they said they

knew there was a torch in the office and would take a handover sheet with them so they had a list of resident names and room numbers to give to the fire service when they arrived. They said they would leave the building and take any residents who were up and walking around with them but would leave everyone else in the home because they were all behind locked fire doors. The staff were not aware of the evacuation procedures or that it is the responsibility of the staff on duty to evacuate people to a safe zone in the home or to start to evacuate them from the building. This meant that people were placed at risk of harm.

There was one piece of equipment, a ski pad, stored on the half landing between the first and second floors in the third house, to help evacuate people who required support when passenger and stair lifts could not be used. Staff were aware of the ski pad and how to use it but acknowledged that, depending where and when the fire was, this may not be enough equipment to move people safely. Following our inspection the registered provider confirmed that an additional ski pad had been purchased.

On the second day of our inspection the registered manager showed us an emergency box in the office that contained a resident list, foil blankets, first aid kit and torches. When we checked the list, we found that it was dated October 2017: some people on the list were no longer in the home and new people had moved into the home who were not included on the list. None of the night staff were aware of this box and when we asked day staff later, they were not aware of it either.

Each person living in the home should have a personal evacuation emergency plan. (PEEPS) This should contain up to date information about the person and incorporate information on what assistance the person requires to evacuate. An up to date hard copy should be available at all times so that attending fire crews have access to this information.

The service was in the process of transferring their records to a computer system and this included a PEEPS form to be completed for each person. These were incomplete and had not been printed off for staff to have access to in an emergency. There was also PEEPS file in the office which was out of date: there was information for three people who were no longer in the home and there were two people who had moved into the home and no PEEPS had been created. The PEEPS in the file contained very brief and possibly out of date information about each person's mobility needs day to day in the home. E.g. hoist and wheelchair, Zimmer frame but no indication of how to help them evacuate the home, especially if the lift and stair lift could not be used. Staff we spoke with were not aware of this file. This meant that there was no correct, up to date information for staff or emergency services in the event of an emergency at Reside at Southwood.

A requirement of the Regulatory Reform (Fire Safety) Order 2005 is that services such as Reside at Southwood should have a Fire Risk Assessment (FRA). The fire risk assessment format used by Reside at Southwood had a scoring system. The FRA was carried out in was 57.3% and rated Amber. There is a pre-printed statement on the FRA which states that, "The target is 70% minimum to achieve green. Issues must be dealt with immediately." This was dated 4 October 2016. There were 43 corrective actions noted on the FRA. The registered manager was not able to confirm which, if any of the items, has been attended to.

A check of fire doors carried out by maintenance staff for the provider in November 2017 identified 46 fire doors that had gaps around them, 33 that had issues with seals and 17 that weren't closing properly. It was not clear whether some doors had more than one issue. Again, the registered manager was not able to confirm whether these issues had been addressed.

Fire drills must be carried out regularly to test the effectiveness of the emergency evacuation strategy, check staff knowledge and understanding and familiarise them with the process and ensure that people can evacuate the building safely. Records showed that fire drills were being held but these included only a roll

call of people in the building. No simulation or evacuation took place.

Due to these major concerns regarding fire safety in the home, we advised the registered manager immediately and made a report to Dorset and Wiltshire Fire and Rescue Service on 31 January 2018. A fire safety officer visited the home on 1 February 2018 and issued a letter containing a schedule of works which must be completed within a maximum of three months in order for the service to comply with Regulatory Reform (Fire Safety) Order 2005. This was in addition to a schedule of works issued by Dorset and Wiltshire Fire and Rescue Service in November 2017 following information of concern that was received by CQC and passed to the fire service.

Records for the two through floor passenger lifts, two stair lifts and lifting and handling equipment including a bath hoist and mobile hoists showed that these were regularly checked and serviced. Service certificates for both passenger lifts, both stair lifts, a bath hoist and two mobile hoists included recommendations for work to be done dating back to July 2016. The registered manager was not aware work had been recommended and later confirmed with the provider that this work was not necessary for the safe working of the equipment.

During a tour of the building we found that many of the rooms had damage to ceilings and walls either from water leaks or general wear and tear. Some carpets were worn. There was a rip to the carpet in one bedroom which was more than 20cm long and was a trip hazard.

Most portable electrical equipment items in the home had a label which stated the item had been tested and passed as satisfactory in June 2016 (PAT). The labels also stated that the items should be re-tested by June 2017. This included kitchen equipment, vacuum cleaners, electric profiling beds, hoists and items such as televisions and radios. A very few items did not have evidence on them that they had been PAT tested or when they were supplied to the home and therefore were too new to require testing. We also found an electrical plug for a pressure relieving mattress was broken but was still in use. The person who was living in this room was very frail. Staff confirmed the person could not use a call bell and could not mobilise without the support of two staff. Had a fire started due to the condition of the plug they would not have been able to evacuate from the room or call staff for assistance. We raised this with the registered manager who confirmed that full PAT testing was planned to be carried out every two years and that visual checks were completed regularly in between full tests. However, records showed that visual checks were carried out of electrical sockets only and not of the wiring and plugs for individual items. This meant that there was no effective system in place to ensure the electrical safety of items used by people and staff in the home. The registered manager later confirmed that the damaged plug had been replaced.

Systems to prevent to the occurrence and spread of infection were not effective. Surfaces to vanity units around wash hand basins, bedside tables, chests of drawers and wardrobes had unsealed and cracked surfaces which created an infection control risk. A few dining room chairs and arm chairs had worn or slightly torn coverings that also created an infection control risk.

Many of the wash hand basins in people's rooms did not have a plug. This would make it difficult for people or staff to have sufficient hot water to wash effectively. The registered provider later confirmed that plugs were provided for those people who were able to independently use a wash hand basin. The communal bath on the ground floor had the plug attached to the bath by a piece of string. This looked dirty and would not be possible to clean thoroughly and effectively. The registered provider later stated that staff mainly fill bowls with hot water to support people to wash and that plugs are provided where people require them.

At the start of the inspection we saw that there were two bathrooms with no waste bins and other bins in the

home were not foot operated to allow waste to be thrown away without contact with possible contaminated surfaces. We also found used continence products left in a swing top bin in one of the communal toilets and a bin full of used continence products without a lid left in the laundry. The outside wheelie bin that contained used continence products waiting to be collected from a waste contractor was not locked and was kept at the front of the building. This was accessible to the general public and anyone who left the building. By the third day of the inspection, three foot operated bins had been provided one in a communal bathroom, and one in the laundry. Another foot operated bin had been situated in the hallway between the laundry, kitchen and dining room to store used continence products. Whilst this was an improvement there were no hand washing facilities close to this bin for staff who were disposing of incontinence products.

Laundry was undertaken in two areas: there were two washing machines and two tumble driers stacked on top of each other in one room and clean laundry was sorted and ironed in another room. In the room with the laundry machines, part of the floor was not fully sealed and some areas of the walls were damaged and not sealed. This meant they could not be properly cleaned. There was a small wash hand basin but access to this was very restricted as cleaning chemicals were stored on the floor in front of it. We asked staff how they washed their hands after handling dirty or contaminated laundry. They told us that they wore disposable gloves and it took much prompting for them to say that they also washed their hands either by climbing past the cleaning chemicals to the laundry wash hand basin or by using the wash hand basin in the kitchen or in a communal toilet at the other end of the building. This meant that surfaces could not be easily and effectively cleaned and people and staff may not have been able to wash their hands and dry them properly to ensure potential infections were not transferred.

Legionella is a water borne bacteria that can be harmful to people's health. To prevent this hot and cold water should be stored and circulated within specific temperature ranges and in areas where water may stand and become stagnant, such as seldom used shower heads and taps, periodic flushing should be carried out. Many of the bedrooms had ensuite baths which were no longer used; the tap heads had been removed in these baths. There were also communal baths and showers that were no longer used. Again, the tap heads had been removed. Some shower rooms had been turned into storage areas. We reviewed the system the registered provider followed to ensure their water systems were safe. The registered manager stated that the provider's maintenance team were responsible for completing the required checks. There was a certificate confirming that the water had been tested for legionella in May 2017 and was clear. Records of regular flushing had been completed in November 2017 together with notes that it was not possible to flush those areas where tap heads had been removed. There were no records of temperature checks and flushing systems prior to November 2017 or after this date in the files and documents that we were given. This meant that proper steps to reduce the risk of legionella and protect people in the building had not been taken.

The service had used a recognised risk assessment tool to assess whether people living in the home were at risk of malnutrition. The tool had not always been used correctly and consequently some of the assessments were incorrect. Where assessments were completed appropriately and had identified that people were at risk, the action being taken to reduce the chance that someone could be malnourished was not clear; care staff and kitchen staff had different opinions about which people were at risk and required additional support such as fortified meals, a special diet or consistency of food, or assistance to eat their meals. Staff were keeping records of the amount people ate over each 24 hour period. However, there was no guidance or information in care plans to guide them about how much people should eat and what to do if people were not eating well.

Some people had lost weight; the registered manager advised that the person's GP would have been

informed of this and the GP would make referrals as necessary to Dieticians or Speech and Language Therapists (SALT). Some people had been prescribed special high calorie drinks and others had been prescribed special thickeners to change the consistency of their drinks to enable them to swallow more easily or reduce the risk.

Some people had been assessed as being at risk of developing pressure ulcers and skin damage. During the inspection we saw a range of different pressure relieving cushions and mattresses were in use. There was no information in people's care plans about the specific type, make or model of equipment provided to reduce the risk or if there were any specific settings that equipment should be set at. There was also no information about how a decision to use specific equipment had been reached. The provider later advised us that only two of the mattresses used in the home required setting manually. We found one of these mattresses during the inspection but were unable to verify what the setting should be as this had not been assessed and recorded in the person's records. This meant that the pressure relieving mattress may not be fully effective.

At this inspection we found that some people had rails fitted to their beds to protect them from falling out of bed. Guidance issued by the Health and Safety Executive (HSE) includes that, where possible, bed rails should be integrated rather than rails that need to be attached. Three people were using older style beds with rails that attached separately. There were large gaps between the mattress and the ends of the bed and the rails themselves were loose. Protective bumpers were placed over some but not all of the bed rails. In one case these had not been properly secured and in another the bumpers were cracked and dirty. The HSE guidance clearly states the maximum and minimum dimensions for the rails, mattress heights and any gaps in order to try to prevent injuries to people. None of the records that we saw confirmed that measurements had been checked for these beds. No risk assessments had been completed to ensure that this was the most suitable and safest course of action to be taken. Once fitted, there were no assessments to check that they had been fitted correctly and there was no evidence that the rails were checked regularly to ensure that they remained safe to use.

The registered manager told us that there were 10 people who required support to move from beds to chairs or wheelchairs with the use of a hoist, occasionally other people required this support if they were unwell. There were three mobile hoists in the home and a fourth which stayed in one person's bedroom. We observed, and discussions with the staff confirmed, that due to the number of people who needed a hoist to help them and the lay out of the building, this was not enough equipment as people sometimes had to wait for items to be fetched from another area of the home or other people were already using equipment.

We witnessed three incidents of poor moving and handling over the course of the inspection. We immediately highlighted these to the registered manager and also made safeguarding referrals to the local authority. The registered manager took immediate action in relation to the poor practice we had identified and ordered an additional hoist. The operations manager confirmed on 28 February 2018 that they had reviewed the moving and handling training given to staff and that not all staff were following the training they had been given. The registered provider later added that this was down to lack of leadership on the floor and not the training as the training contents had been externally verified.

Some people needed help to change their position when in bed. We did not see any equipment to help people do this and there was no information in care plans about this. One person was being cared for in bed. We observed one member of staff reposition them and provide personal care without support from a second member of staff. The member of staff was of the opposite gender to the person who was receiving support. We asked the member of staff what the moving and handling plans were for the person and whether they had consented to receive personal care from a member of the opposite gender. They were unable to answer this and care plans did not contain this information. We made a safeguarding alert to the

local authority about our concerns for this person. The registered provider later advised that repositioning equipment was available in the home.

Many of the people living in the home were unable to use the call bell to summon assistance from staff. Risk assessments to review the level of concern this may indicate had not been completed. Staff told us that, when people who could not use their call bell spent time alone in their rooms, regular checks on them were carried out. We asked to see records for this and staff confirmed that in most cases, during the day, records were not made. A record of checks for one person was provided but these were recorded on a form with pre-printed times. The registered manager acknowledged that it was unlikely that staff would have completed the checks at these times and acknowledged that contemporaneous records with the actual time of the check should be made. Staff on the night shift confirmed that everyone was checked every hour. Again, records of actual times of checks were not made and no risk assessment to establish whether checks at shorter or longer intervals were required had been carried out.

Analysis of accident records for a two month period showed that 37 accidents and incidents were recorded. Twenty-one of these accidents had occurred during the night shift and all except one had been unwitnessed by staff. Records indicated that these accidents were mostly discovered during the scheduled hourly checks that staff completed. Two people had experienced a number of falls over this period which accounted for 14 of the 37 incidents. No falls risk assessments had been completed and there was no evidence that any action had been taken to reduce or mitigate the risk of falling for these people.

During the inspection the Health and Safety Executive notified CQC that one of the people living in the home had sustained a serious injury. We looked at the circumstances surrounding the accident and found that a piece of furniture had fallen on top of the person. We checked care plans and risk assessments that stated the person was at low risk of falls because they had not experienced any falls in the previous 12 months. Accident records showed that the person had fallen five times in the previous four months. Prior to the fall where the person sustained the serious injury, an accident record showed that five days earlier the person had a fall involving the same piece of furniture but no action had been taken to reduce the possibility that this could recur. There had also been no analysis of the previous falls which all took place during the night shift. The incident occurred after we raised the concern about staffing levels at night and the registered manager had advised that there would be four staff on duty on night shifts. The staff rota for the night of the accident showed that three staff were on duty.

We asked to see risk assessments for people's care needs in relation to the rooms they occupied. The operations manager and another member of staff confirmed that these were not carried out. During a visit to other bedrooms we identified that there may be other items of furniture that could be unstable if people fell against them or used them for support and that not all hot surfaces such as radiators had been adequately covered to prevent people from sustaining injuries.

We discussed some of the risks to people that we had become aware of with some of the staff. They were not aware of the risks people faced or how these risks should be managed. For example, staff were not aware of the implications of dehydration or malnutrition or the entrapment risks posed by improper use of bedrails. This meant that effective measures to mitigate the identified risk had not been put in place.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured that risks to the health and safety of people had not been assessed and steps to mitigate the risks had not been taken, that the premises and equipment is safe to use and was used in a safe way, that suitable equipment to meet people's needs had been provided and steps had not been taken to assess the risk of, prevent, detect and control the spread of infections.

This was also a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured that there were suitable numbers of staff on duty to meet people's needs.

There were systems in place for the management and administration of medicines but we found that these had not always been followed. We looked at the medicines administration records (MAR) and found that these were not always signed by staff to confirm that the items had been administered or a code letter had not been used to explain what had happened in the event that a medicine had not been administered. This was particularly the case for the administration of topical items, such as prescribed creams, that were kept in people's bedrooms. For example, prescribed creams that should have been applied twice a day, so should therefore have been signed for 48 times in the preceding 24 days, had only been signed for 23 times; there were seven days where there was no signature, six days where the cream had only been applied once and 11 days where the cream had been applied twice as prescribed.

Some people were prescribed medicines to be taken as and when they needed them (PRN). There were no care plans for some of these medicines and no information to guide staff about when to administer them if the person for whom they were prescribed was unable to request them. This included a specialist pain relief medicine and other medicines to help manage people's pain.

There was an incident report from a health professional who advised the staff to give the person paracetamol to help manage their pain until a paramedic arrived. The home stated that they could not do this as the person was not prescribed pain relief and no homely remedies were kept in the home. The registered manager advised us that this was a company policy. However, this is in contradiction to local and national medicines policy guidance which recognise that there may be a need to treat minor ailments or provide immediate relief such as pain relief, on a short term basis.

Analysis of records of the serious accident that occurred during the inspection, showed that the person waited six and a half hours for an ambulance and during this time did not receive any pain relief. Their care plan stated that they were prescribed paracetamol on an "as required" basis. We checked the MAR and medicines trolley and there was none available for the person. We asked staff about this and were told that the person concerned could not tell people, because they were living with dementia. The service had a tool for assessing pain in people who have difficulty, or cannot communicate but this had not been used. This meant that people were not receiving pain relief appropriately.

On three days of the inspection we noted that the medicines prescribed to be given at 8.00am were still being administered at times past 10.30am. One member of staff told us that, if any medicines should have a specific gap between doses, they would not give the next dose at 1.00pm as planned and would withhold this until later in the day. However, it was evident in discussions with staff that not all of them were aware of this issue and also no consideration had been taken of other factors influencing why medicines had been prescribed to be given at specific times. In addition, we found that where people were up and awake towards the end of the night shift, night staff were administering 8.00am medicines earlier than the prescribed time. The actual times of administration were not recorded which meant that staff on different shifts may not be aware that times of administration were not as prescribed and the lengths of time between doses could therefore be too short or too long.

Handwritten additions to the MAR did not always include the full name of the prescribed item, the dose and full information that would have been on the prescription label and should therefore have been transcribed onto the MAR. Entries had not always been signed and there was no second signature to confirm that the entry had been checked and was correct. This meant that a system to check for possible errors was not in

place.

Some people had their medicine administered covertly, disguised in their food or drink. For these medicines there was no advice from the pharmacist to confirm the medicines would remain effective and their therapeutic properties would not be affected. We discussed this with staff, who were not aware advice from pharmacists was required when altering medicines in such a way. The registered manager later confirmed that staff had sent forms off to the pharmacist to obtain guidance but these had not been completed and returned to the home and no action had been taken to address this.

Staff had been trained in the administration of medicines and records showed that their competency to administer medicines safely had been checked regularly. However, none of the shortfalls in medicines identified during this inspection had been highlighted by staff. The registered manager had completed some audits of medicines but had not identified all of these issues. This meant that people may not have received some of their medicines as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

We looked at the records for four recently recruited members of staff. Within each file we found the service had obtained proof of the person's identity and had a copy of a recent photograph. There was limited evidence of satisfactory conduct in previous employment or good character. This was because references had been provided by colleagues rather than the applicant's previous employer or line manager. Testimonials had been accepted. That is, a letter written to no specific person by a referee about the general qualities of the person and not specific to the job the person had applied for. The registered manager had not obtained complete employment histories and where there were gaps in applicant's employment, had not sought explanations. In addition, one reference included information that an applicant had received a final written warning. There was no information about this or why the decision to employ the person had been made. The registered manager confirmed that they had not investigated this.

A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. One person had provided a copy of their Disclosure and Barring Service (previously known as the Criminal Records Bureau) check from a previous employer which was more than three months old. This was not valid because the registered manager had not taken action to check there were no changes to the record. Additionally, the employer shown on the person's DBS record was not shown as a previous employer on the employment history that had been given in the application form and the registered manager had not explored why this was.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe recruitment of staff.

Staff told us that they believed there were not always sufficient staff on duty to meet people's needs and added that the lay out of the building meant that staff were spread out and not always easy to find. Staff said they felt they had to rush from one task to another and people told us that staff were often rushing from one job to another and rarely had time to spend with them. We were especially concerned about the number of staff on duty at night when taking into account the high level of care and support people required together with the layout of the home. An analysis of accidents also showed that more than 50% of accidents occurred during the night shift period from 8.00pm to 8.00am. We discussed our concerns with the

registered manager who acknowledged that there had previously been four staff on duty at night and agreed to increase staffing at night back to this level.
These shortfalls were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were insufficient staff on duty at night.

Staff spoke knowledgably about the different types of abuse that people may be subjected to. They knew the procedure for reporting allegations of potential abuse and who to contact for advice and guidance. Training records confirmed staff had completed their safeguarding adults training courses and received refresher training when required.

Inadequate

Is the service effective?

Our findings

People's rights were not protected because staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) when seeking people's consent to care. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed.

When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Care homes must follow the Deprivation of Liberty Safeguards otherwise this is unlawful. There were conditions attached to the DoLS authorisations for two people living in the home. For one person conditions included that they must have their psychotropic medicines reviewed regularly and that they must be supported to go outside for walks at least once a week was not being met. These conditions had not been complied with. We were unable to check the conditions for the other person as they were not at the home during our inspection.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had not followed the requirements of the Deprivation of Liberty Safeguards.

Where people lacked capacity to make decisions or give consent, staff did not act in accordance with the MCA. Mental capacity assessments and best interest decisions had not been fully completed in line with the principles of the MCA. There were gaps in mental capacity assessments of people's capacity, least restrictive options had not been considered and those with legal authority had not been involved with decisions. For example, some people needed to have their medicine administered covertly disguised in their food or drink. There was no best interest's decision for this. In addition, people had been given a flu jab. The registered manager confirmed that they had not completed a mental capacity assessment or best interest's decision for this. They stated that they had consulted people's next of kin. However, in some cases, people's next of kin did not have the legal power in the form of a lasting power of attorney, to make such decisions for people.

Everyone in the home was living with dementia. All of the bedroom doors had Yale type lock on the door. All of the doors locked when they shut and staff had to use keys to access rooms whenever they wanted to enter one both during the day and night. None of the people living in the home had keys to their doors and we saw that when people wanted to go to their rooms, they had to ask staff to open the door for them. Many of the people were living with dementia and may not understand the lock mechanism and how to use it if they wanted or had to leave the room and those that did, or may not have the manual dexterity to operate the lock. This meant that people could not move freely about the home because they could not

access their rooms when they wished and for those people who were not at risk if they left the building unaccompanied, could not open external doors independently and they may have had their rights to freedom unlawfully restricted.

These shortfalls were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

People did not receive support from staff with the knowledge and skills they needed to carry out all aspects of their roles. All of the people at Reside at Southwood were living with dementia. Training records showed that all except four staff with caring roles had completed basic dementia awareness training. Supervision records for two staff showed that they had requested additional training in 2017 but this was yet to be provided. We saw poor practice at times; one person who asked repetitive questions was frequently ignored by staff. Another person who liked to walk around the home and would pick up and look at objects that they found, often had the objects taken from them with little or no explanation from the staff. We observed one person sitting in the dining room repeatedly asking, "what should I do now?" Initially staff responded that they could go to another lounge to watch television or go to their bedroom. The person did not appear to know where these areas were so they remained seated and asked the same question at regular intervals for a period of more than 30 minutes. After prompting from our inspector, staff gave the person a magazine to look at which they sat looking at for around 15 minutes.

Some people needed positive behaviour support from staff because they were living with dementia. Commissioners told us that they had concerns that staff had not received adequate training to support people appropriately. Some staff told us they did not feel equipped to support people with behaviour that challenged other people and supervision records also reflected this. Training records showed that only 11 of the 22 care staff had completed this training.

Skills for Care is a national organisation that sets the standards of knowledge and competency that people working in adult social care need to meet before they can safely work unsupervised. All staff who are new to care or who do not have satisfactory evidence of previous experience and training should complete basic training called the Care Certificate. Two members of staff had joined the service in February and March 2017, were working unsupervised in the home but had not completed the Care Certificate or work equivalent to this. Two out of three staff on the night shift at the start of our visit on 30 January 2018 had not completed this training and may therefore not have had suitable knowledge and competency to provide the care required by people living in the home.

Following on from the Care Certificate, Skills for Care sets a recommended frequency that staff should refresh their skills and knowledge and their competency should be assessed. Records showed that four staff had not completed refresher training in the essential areas which include health and safety, the MCA and DoLS, fire safety, safeguarding adults, infection prevention and control, emergency aid and food hygiene. Skills for Care also include a module of training in nutrition and hydration. There was no evidence that any care staff had completed refresher/update training in this area. The registered provider later confirmed that kitchen staff had completed courses in nutrition and hydration.

Some of the people in the home were living with conditions such as epilepsy, Parkinson's disease and diabetes. One member of staff had completed a distance learning course on diabetes but no other specific training had been given to staff in any of these areas. This meant that staff might not always be able to deliver care and support to people safely and appropriately. The registered provider later confirmed that information was available for staff.

Supervision of staff is important to enable them to discuss their work, resolve any concerns and plan for any future training they need or are interested in undertaking. The registered manager had delegated the supervision of staff to other senior staff. Records showed that people had not received the number of supervisions that the provider's policy stated they should expect. Staff told us that they had not been provided with regular supervision and raised concerns about the quality of some of the supervisions they had received. We looked at training records for staff in supervisory roles. We could only find evidence that one member of staff had completed training in team leadership but could not confirm that this had included supervising staff.

These shortfalls were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not supported with regular training and supervision.

People were not effectively supported to ensure they had enough to drink and identify changes to meet their needs. When low amounts had been drunk by a person no action had been taken. Staff told us concerns about people not drinking enough were discussed at handover meetings in the morning. Handover records were not detailed and did not document how much fluid people had drunk the previous day. Records showed that some people had drunk very little but there was no evidence that any action had been taken. During a handover between shifts at 8am, a member of staff reported that a GP had telephoned the day before with test results for one person and this included information that the person was dehydrated. Staff were instructed to encourage the person to drink during the day. At 3pm that day we checked to see what the person had eaten and drunk and found that a fluid chart had not been started so there was no record of what the person had been offered, how much they had consumed and whether they had needed help to drink. Staff could not tell us what the person had drunk.

Good practice in dementia care recommends that people should have free access to food and drink. People living at Reside at Southwood did not have access to drinks and snacks in between planned meals and morning coffee and afternoon tea breaks. We observed that when people sat in the lounge there were no drinks sitting beside them to have a drink outside of these times.

Meal times in the home were busy with a high proportion of people requiring assistance and supervision. People either made their own way to the dining room when prompted by staff or those with mobility difficulties were assisted there by staff before they began to serve the meal. This meant that some people waited at the dining table for more than half an hour before their meal was served. On two occasions we saw people leave the dining room because they had been waiting at the table for a while but did not appear to understand why they were sitting at the dining table. Staff then had to spend time finding the person and encouraging them to return to the dining room. Meal times were quiet with little interaction between people and staff except for task focussed interactions such as offering choices of meals or trying to prompt people to eat.

People were offered a choice of two items for each course. Meals were presented to people on a plate and staff also explained what the meal was to support people in making their own decisions where this was possible. Staff served meals to people from a list of names rather than by table order. This meant that some people on a table had to watch other people at that table eating but had no food to eat themselves. Some people waited up to 20 minutes to receive their food. We noticed that some people ate very little and staff removed their unfinished meals without offering them support or suggesting other foods which may have encouraged them to eat. During our observations we noted that no one was offered salt, pepper or any other condiments. The registered provider later stated that food is seasoned in the kitchen and some people did have salt and pepper on their table or in their rooms. They also stated that condiments could not be left out because some people may drink them or put them in their drinks.

People who needed support from staff to eat had their meals placed in front of them but they then had to wait up to 30 minutes before staff were available to assist them. During this time they sat with the sight and smell of food around them and watched other people eating. When staff did provide support, none of them checked to see if meals were still warm and very few of the staff took time to explain what the meal was or take the opportunity to make the meal time a social event.

There was no information in care plans about what to do if people failed to have sufficient food and fluid and there were no entries in the daily records that we looked at about any actions that had been taken to encourage people to eat and drink better.

Some people had been identified as at risk of malnutrition, had swallowing difficulties or required a special diet. Kitchen staff and care staff had differing views of who these people were and how they were supported. For example, some people had been prescribed fortified drinks but the kitchen staff were not aware of this and we could not be certain through our discussions that they were therefore aware that these people's diets should also be fortified with additional calories. Other people were living with diabetes and we were told by staff that they should be provided with a "diabetic diet" to help manage this. Again, kitchen and care staff had different views of which the people were that this applied to. During the inspection we found that a number of people had unplanned weight losses and we made safeguarding alerts to the local authority about this.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's nutrition and hydration needs were not being met.

People were supported to access healthcare services when needed. People were referred to healthcare professionals when needed including, the GP, tissue viability nurses and mental health professionals. Healthcare professionals felt confident in the clinical staff's judgements and referrals made. One health care professional told us, "They will ring to seek guidance". Another healthcare professional told us they were notified straightaway of any concerns, staff were very caring and staff always know they are coming.

National good practice in dementia care such as that produced by the University of Stirling's Dementia Service Development Centre suggests that buildings accommodating people living with dementia should be designed and decorated in a way that supports people. For example, doors should be in a contrasting colour as should toilet seats and handrails and there should be easy to read signage. Most people had a photograph of themselves on their bedroom door and there were pictorial signs on bathroom and shower doors. The internal doors and handrails at Reside at Southwood were painted in pastel colours. Some toilet seats had contrasting coloured seats to help people locate toilets easily.

We recommend that action is taken to review the accommodation with regard to best practice guidance about creating dementia friendly environments.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. Some staff were kind, caring and positive. People and relatives spoke highly about some staff. Comments included, "I give them 100%, the staff are so caring and there is always plenty of them." A relative told us that staff were always attentive whenever they requested that something was done.

Some staff had a friendly and relaxed way of communicating with people and this meant some people laughed, smiled and responded positively to them. We saw some staff spending individual time with people playing cards and talking to people. We also saw some staff comforting people at times and people looked visibly comforted and content with this physical contact. However, our observations showed that not all people were treated in a respectful way and care provided was task led. We observed staff ignoring people who were trying to gain their attention and not talking to people before assisting them. For example, one person was transferred from a chair to a wheelchair by a hoist. Staff spoke very little to the person and then left them hanging in the hoist for longer than was necessary because they had not ensured the wheelchair was close by ready for the transfer. This was done in a communal area with other people watching and although there was a privacy screen in the room, this was not used.

During the inspection we did not observe any baths or showers taking place. Records stated that people had received strip washes but we could not find records of baths or showers. Staff confirmed that they rarely helped people to bath or shower and it was general practice for people to have strip washes only. The registered manager said that this was not the case and people did have baths and showers.

One person needed support with all aspects of their personal care. At the time of the inspection they were very frail and were being cared for in bed. We observed that personal care and repositioning was done by one member of staff who was not the same gender as the person receiving the care. We asked if the person had confirmed they were happy to receive care from staff of the opposite gender. The member of staff concerned did not seem to understand the question. There was no information in the person's care plan, or any of the other care plans we saw, about people's preferences for their preferred gender of staff for personal care.

We observed that staff were addressing two people by different names; the registered manager confirmed that these people had nicknames as well as their given name. For one of these people, records clearly stated that they wished to be known as their nickname and not their given name. The person was living with dementia and may find it difficult to be addressed by two different names. This was also the case with the other person. When we discussed this with staff they were unaware that people had specified how they wished to be addressed.

People were not always supported in line with their preferences. One person was escorted to the dining room at tea time; they were wearing a dressing gown and were telling people that they were very cross because staff had woken them up and insisted they come for tea when they had explained that they were not hungry and felt tired. We saw that the person ate very little and returned to their bed as soon as

possible.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because people's dignity was not promoted and protected and people's choices and decisions were not respected.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were not always fully assessed and planned for and people and their relatives had frequently not been included and involved in the process. For example, people with conditions such as diabetes, Parkinson's disease and epilepsy did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur. This was also the case when people had a short term condition such as an infection or a wound. Staff we spoke with had an understanding of these needs and were able to tell us how they provided support but this may not have been known by all staff. There was therefore a risk that people may not always receive the support they required.

All of the care plans we looked at contained omissions or inaccuracies, either because initial assessments had lacked detail or because people's care needs had changed and these had not been reflected in assessments and care plans.

During the inspection around 10 people were diagnosed with chest infections and prescribed antibiotics. Lots of people were suffering from coughs and colds and we could see that they were feeling unwell. Staff still brought people to the lounges and a high proportion of people spent long periods of the day sitting in armchairs or wheelchairs with a blanket over them. Those in arm chair did not have foot rests or any way of reclining restfully. The registered provider later confirmed that there were two reclining chairs and footrests available in the home.

A number of people at Reside at Southwood were living with diabetes. There were no care plans to indicate the type of diabetes they had, outlining what the condition meant to the person, how it affected them, how it may progress and any risks such as high or low blood sugars, or other possible complications. There was also no information about the medicines people took to manage their condition or whether the timing of their visits and meals was important in managing the condition. We made a safeguarding referral to the local authority about our concerns for diabetes support in the home.

The registered manager reported that all of the people living at Reside at Southwood were living with a diagnosis of a cognitive impairment or dementia. There are a number of different forms of dementia and each has specific symptoms, complications and development. Very few of the care plans that we checked stated the type of dementia the person was living with. None of the care plans stated how the particular form of dementia might develop and affect the person or any particular risks or concerns related to the type of dementia the person was living with.

Staff completed daily records for each person. These provided staff with information about how the person had been during the day. On occasion the records identified an issue or concern that needed to be followed up. Records were not kept about the actions that were taken or how the issue or concern was resolved. We also identified two occasions where records were incorrect: one person had been unwell in the dining room, had left before their lunch was finished and a GP had been called. The GP had diagnosed an infection and prescribed antibiotics but this was not recorded. Another person had their lunch in their room. When we

visited them they were in bed and unable to access their meal. A member of staff tried to encourage the person to eat but recognised that the meal was cold and the person was unlikely to eat it. Entries for both of these people in the records stated that they had eaten all of their lunch and were having a good day.

There was little or no information about people's wishes for end of life care and support if they should require this whilst at the home. It was not always clear whether Do Not Attempt Resuscitation (DNACPR) orders for people were in place. DNACPR means that people have chosen not to receive cardio-pulmonary resuscitation (CPR) if their heart stops beating. In some instances, this information was in the front of the person's file. However, there were also instances where this information was not readily accessible to staff in the event of a medical emergency and there was therefore a risk that treatment that was against their wishes would be provided.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

We were not able to fully assess how the service supported people and their family and friends at the end of their lives. This was because at the time of the inspection no one was receiving end of life care.

The service had received two complaints in the previous twelve months. Records were not always consistently completed. Records showed the complaints had been acknowledged with the parties involved but not all of them showed if a conclusion had been agreed and actions had been completed. We discussed this with the registered manager who told us all complaints had been fully resolved. We recommend the provider ensures a full audit trail is followed in accordance with the provider's complaint policy. There were also a number of cards and letters from people and relatives thanking the staff for the care and support they had provided.

Inadequate

Is the service well-led?

Our findings

Although people and relatives told us they were happy with the service, we identified a number of areas of concern where improvements were needed. The provider's statement of purpose for Reside at Southwood states that "Reside aims to provide a person centred service for older people with any form of dementia." Their website states, "We specialise in providing care and support for those with varying degrees of dementia." We identified shortfalls in how the service provided care for people living with dementia. For example, the failure to work in accordance with the Mental Capacity Act, the practice of locking doors was not in accordance with current good practice in providing care for people living with dementia. The registered provider later pointed out that they did provide signage, a dementia friendly garden and activities which were in accordance with current good practice.

Arrangements to monitor the quality and safety of the service provided were not effective. Ten breaches of regulations have been identified and a number of safeguarding alerts have been made to the local authority.

Following the inspection the registered provider told us audits and management processes had identified some of the shortfalls. However we saw that some audits had not been completed fully, where shortfalls had been identified action plans were not in place or had not been completed.

The registered manager did not know if surveys and questionnaires had been sent out to seek feedback on the quality of the service provided. The registered provider later provided evidence that surveys had been completed and satisfaction levels had been noted.

A number of records, including care, medicines and staff records, were not dated, timed or signed. In addition, some records were illegible. Records also lacked detail and information or included inaccuracies and omissions. Other records, such as care plans, contained out of date information as well as current information, but it was not always easy to establish which was the current information that staff should be following.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

With the exception of notifications about people who had passed away whilst living in the home, we had not received notifications about a number of other events and incidents. The registered manager stated that they had not been aware of the requirement to notify some incidents and had overlooked the notification of other incidents. There were at least two significant injuries and a number of safeguarding concerns which had not been reported.

Registered persons are required to notify us of any allegations of abuse at the home. The local authority had made us aware of allegations of abuse that had been investigated by them. However, we did not receive any

notifications about allegations of abuse from the registered provider or registered manager.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the registered persons had not notified us of all incidents.

The service's previous inspection rating was displayed in the main entrance of the home and on the provider's website.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Proper steps had not been taken to ensure that people receive appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not promoted and protected and people's choices and decisions were not respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service had not acted in accordance with the requirements of the Deprivation of Liberty Safeguards.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

People were not protected against the risks associated with the unsafe recruitment of staff.