Making Space

Liverpool Mental Health Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Liverpool Mental Health Services on 16 February 2016, we returned for a second day on 18 February for which we gave notice.

Liverpool Mental Health Services provided support to people primarily with mental health support needs. They supported 37 people living in their own homes. 31 people were supported at five locations across Liverpool, these were small blocks of flats ranging from 13 to 4 flats in each block. Six people were supported by community based floating support. Liverpool Mental Health Services provided people with care and support. They did not provide people with accommodation.

A person was in the process of applying to be the registered manager. At the time we visited there was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found a number of breaches relating to safe administration of medication, assessment of risks, staffing, consent in relation to the Mental Capacity Act (2005) and lack of good governance.

You can see what action we told the provider to take at the back of the full version of the report.

We found that people's medication was not stored, documented or administered safely. There was an excess of old medication stored. There were examples of incomplete records and inaccurate guidelines for support staff. There had been times when people had not been administered their medication or had been administered a discontinued medication. One person had incomplete records and the provider was unable to tell us what medication they had taken.

We observed that risk assessments were inconsistent. We observed examples of effective and ineffective risk assessments. Assessments had not been effective in keeping people support and staff safe. Staff had not been training in deescalating situations despite the provider being aware of incidents.

There was an inexperienced staff team and a recent overreliance on temporary staff. The newer staff members had not received appropriate training or effective documented induction. At times inexperienced staff were inducting new staff members.

The provider was recruiting more staff. They had organised the role of tenant representative for a person supported. They were involved in interviewing and choosing new support staff.

We found that the provider did not meet the requirements of the Mental Capacity Act 2005 (MCA). They had

not assessed a person's fluctuating capacity in relation to the refusal of their medication or taken into account what effect this decision would have on a person's capacity.

Many people told us they were happy with their care and were supported in their health needs. The staff interaction we observed was caring and we observed a recent change in practice that ensured that staff had the time to sit, chat and get to know people better. People had been supported to socialise and efforts had been made by support staff to reduce social isolation. Recent communal events had been a success.

People's files contained a lot of information about people. They were written in a person centred way and had been updated recently. We saw examples of how these had been effective in guiding the support of some people and times when they had not been effective in responding to people's needs.

The management of the service was described by some staff and people supported as confusing. The manager had not taken the lead in the induction of new staff members or influencing the practice and developing culture of newer staff.

Information from incidents was gathered and stored in an organised way. There was no evidence that this information had been used to improve the support provided to people or to mitigate future risks. Medication audits had been ineffective in improving medication practice and had not picked up errors and bad practice. Records of support provided were of a poor quality and could be contradictory.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

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

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medication administration was often not safe.

Risk assessments did not always acknowledge and mitigate risks.

There was a culture that at times made people and staff feel unsafe.

The staff team had not received adequate safeguarding training.

Is the service effective?

Inadequate

The service was not effective.

There was an overreliance on temporary ad hoc staff.

There was inadequate support for staff during their induction and first few months.

The staff team were not sufficiently skilled, experienced or trained.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring in their interaction with people.

There were not always adequate steps taken to care for a person's wellbeing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The support was inconsistent in responding to people's changing support needs.

People's individuality and choices were respected.

There was a focus on reducing social isolation.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in place.

Audits and assessments of the support provided had not been effective in highlighting problems.

Information gathered had not consistently been used to improve the support provided.

Records were incomplete and at times contradictory.

Liverpool Mental Health Services

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.

We carried out an unannounced inspection of Liverpool Mental Health Services on 16 February 2016, we returned for a second day on 18 February for which we gave notice. This inspection was conducted by an adult social care inspector.

We spoke with six people who were supported by Liverpool Mental Health Services and eight staff members. These included the area manager, team leader, senior support worker, five support workers and a volunteer. We spoke with two social workers and a mental health professional.
We also spoke with one relative of a person who visited during our inspection.

We looked at and case tracked the care files for three people and the staff records for three members of staff. We looked at the medication stocks, medication administration records and medication audits for three people.

We observed care and support of people. We looked round the communal areas of the building at 3 Devonshire Drive. We were invited inside two people's flats. The people supported held their own tenancies with a landlord, and the flats were not maintained by Liverpool Mental Health Services.

We looked at the records relating to incidents and accidents and the policies of Liverpool Mental Health Services. We also looked at the records we held at the CQC.

Inadequate

Is the service safe?

Our findings

We asked some people supported by Liverpool Mental Health Services if they felt safe. They told us they did. One person explained "I feel more safe than I would somewhere else. There is a locked door, and staff available. There is an intercom and you decide who to let in, it's not open to anybody". Another person said there was, "Good staff here to look after us". Somebody else told us they "feel very safe here". One person said they were not safe; after some discussion they were unable to tell us why.

A relative of one person supported told us "When I go I know [name] is safe, I'm at peace because people are downstairs".

One professional we spoke with told us they felt the support kept people safe. Another professional had concerns about people's safety. Two staff members expressed to us some concerns they had about being safe in their work.

We found safety to be inconsistent across the support provided.

We found that medication was not stored, documented or administered safely. People's medication was usually stored in a locked cupboard in their own flat. Some people's medication was stored in a communal medication cabinet, in a separate locked storeroom accessed and administered by support staff.

We looked at the medication and medication administration records (MAR) for three people. One person whose medication was in their flat and two people's medication that was stored in the communal medication cabinet.

We observed medication in the person's flat was not stored safely. There was an excess of medication which needed returning to the pharmacy going back to May 2015. This made administering and checking the current medication difficult and confusing. One staff member told us they only use medication on the top shelf, that's how they know which medicines to use.

Mistakes had been made in the administration of this person's medication. During this week they had missed five doses of one medication and had been given doses of two medications that had been discontinued.

The administration of medication was not recorded safely. The record for the week we visited outlining what medication the person should be taking contained two medications that had been discontinued. Six prescribed medicines were missing from the record. The dose of two medicines on the provider's documents differed from the prescribers. There were medications with a difference between the stock showing on the records and the physical count of the medication present.

There was no distinction on the MAR records or the medication record guide for staff between as required medication (PRN) and scheduled medication. When we asked the staff how they knew, they told us they

take the lead from the person supported. One medication that carried the instructions on the box 'do not stop taking this medicine unless your doctor tells you to' was blank on the record for six doses in one eight day period. The staff member told us the person had refused this medication. This was not recorded; no action was taken to find out what impact this may have on a person or to alert health professionals of the person's decision.

This person supported described to us how an agency worker had, "gave me the wrong times meds, it made me not well. It was the night meds at daytime, I felt all over the place".

The communal medication cabinet was in a walk in cupboard with no working light and no natural light. A member of staff told us this had been reported. The key to the medication cabinet was in the cabinet when the door to the room was opened. One person's old medication was on a table below the medication cabinet. We were told this was due to be returned to the pharmacist. This could have led to confusion when administering this person's medication. The medication cabinet was disorderly. One person's sachets of medication had spilled across many shelves.

One person's medication file we looked at was missing the administration records for the current and previous weeks. The manager and team leader looked for these and were unable to find them. We asked the manager what medication had been administered to this person and they did not know. The medication record for the week previous to this showed that only one morning medication had been administered in the whole week. The other days were blank, not recording if the medication had been offered to or refused by the person. Previous weeks had similar poor recording.

The team leader told us that the relevant professionals were aware of the person refusing their medication, however the provider didn't have any record of this. The provider was unable to work out how much medication this person had taken recently. It was not possible from the records to work out if the stock of medication held for this person was correct.

In people's medication files, important documents providing information to support staff were not always complete. One person told us there is, "Virtually every week a new agency or bank worker". They said the knock-on effects of this could be that their medication is late and not given on time which was important to them.

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the administration of medication was not safe.

The provider's response to risks was inconsistent. One person supported by the provider posed risks to themselves and as an unintended consequence of their actions risks to other people. When they had become aware of the risks, the provider had informed the necessary authorities and organisations. They had kept clear and thorough documentation and were doing everything in their power to support this person and to mitigate risks to them and others.

Another person had repeatedly refused their medication of anti-depressants and anti-psychotics over a period of weeks. The provider had completed three risk assessments in the past three months which had not made mention of this risk. There were no clear guidelines available to staff on how to support the person to take their medication and mitigate these risks. The documentation of support being offered to this person was incomplete and at times contradicted the medication administration records. There was no clear or consistent approach of how they were supporting this person safely.

One staff member told us that after an incident they were asked to look over a person's risk assessment. They told us that because of not knowing the person they were unable to do this effectively saying, "I only knew him for one month, I left a lot how it was". Due to staff members inexperience, risks were not consistently assessed or responded to.

Some of the staff we spoke with told us of times when they didn't feel safe. One staff member said that they thought the organisation was slow to respond when they highlighted a risk to the manager. Another staff member told us they had highlighted situations they had experienced where they didn't feel secure.

There was no record of training being offered to support staff in deescalating situations, using breakaway techniques or keeping themselves and others safe during challenging situations. Night staff were lone working and told us they supported people with night time medication and for other purposes they were in and out of people's flats. They carried a panic alarm which made a loud noise but did not use assistive technology to alert anybody. A mobile phone was used if staff needed any assistance. There were records of incidents were staff may have been at risk, involving day and night time staff that the provider was aware of.

This is a breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because risk to people's health and wellbeing were not assessed.

People supported and staff told us there had been many occasions where people had been asked by fellow tenants to lend them money. This had led to some tensions amongst neighbours in the flats. One person told us "Loads of people tried to borrow money off me". We observed that one flat had a sign outside asking people not to knock and disturb them if they wanted to borrow money. One professional told us they were aware that a person had felt threatened after they described being "forcefully demanded" that they lent a person money. One staff member told us they thought people "can't say no, frightened". We were told by one person that they thought, "Some people get other people to do it for them." Another person told us, "There is an issue with money lending, we've all had a letter – don't get bothered by this anymore". The provider had written to all tenants asking for this practice to stop. Local authority safeguarding had been informed and statutory notifications regarding this had been sent by the provider to the CQC.

Some staff we spoke with told us they had received safeguarding training. This was by means of e-learning which staff told us had taken about an hour. The training records of six recently recruited staff members showed that three had completed safeguarding training in the first three months. Some staff who were providing support to people had received no safeguarding training.

We asked three staff members how they may be able to spot abuse and what they would do if they suspected a person was being abused. Staff we spoke with had a good idea of what to look out for and actions they would take if they suspected a person was being abused. They knew the need to inform local authority safeguarding and some staff had experience of doing this in.

We observed the records of one person who had been recently recruited. The provider had checked their ID and obtained Disclosure and Barring Service (DBS) checks. The provider had obtained two references for people in the recruitment records we checked. We observed one person's file whose DBS check highlighted that they had a criminal conviction, this had been documented and risk assessed appropriately.

We looked at the staffing rota and observed that it was planned for at least two members of staff to be

available during the day. On four days of the week there was an extra person, making three people during the day. There were two staff in the evening and one staff member working overnight on a waking night. The waking night shift was lone working and this was provided by the longer standing members of the team.

The team leader explained that the third person during the day was to support people on a one to one basis as necessary. They also told us, and the rota showed, that there were handover periods between 40 and 80 minutes where there was extra staff available and these periods could be used for smaller blocks of one to one support.

The provider was trying different methods of recording the support offered to people by staff, this was still being trialled. We did not see evidence that the spread of staff support was based upon people's assessed support needs. We were told by staff members that there had been a recent decision made to allow half an hour for people's medication administration, so staff had the time to stop and chat, help a person with something and become aware of any additional support a person may need. One staff member told us that the "Split down of support time is confusing and causes difficulties".

Inadequate

Is the service effective?

Our findings

One person told us that there was "Virtually every week now an agency or bank worker". Another person said, "I have an issue with agency staff, they don't know you. They just come in and are sort of like pitched in at the deep end. Mistakes get made". We asked the person how often this happens and they told us they "Have them quite often, been short staffed, a lot of staff have left". They finished off by telling us, "Sometimes you can't even understand them".

One member of staff told us that recently they had used a lot of agency staff and this caused problems with communication. One person supported told us they thought "There is no communication".

One of the professionals we spoke with told us that "continuity of staff and building up relationships" was important to some of the people they knew who were supported by the provider. They felt this hadn't happened due to a high turnover of agency staff and this had an effect on the people they knew. Another professional thought there had been consistency of support and that "communication is really good".

We reviewed the weekly rotas over a six week period. The provider used a team of three experienced support workers to provide support during the night shifts. However there was not a consistent, experienced and trained team of people proving support during the daytime. In this six week period between 50 and 70% of support was provided by people who are staff with less than three months experience or who are temporary agency workers. At least 23 different named staff provided support to people over this six week period.

We asked staff members what support they received. One staff member told us that "If you need any support they will help you". We were told there are staff team meetings. One staff member told us, "There is an agenda and staff can add items to the agenda". Other staff members described these meetings as 'ok'. We asked staff if they received supervisions from a senior member of staff. We received a mixed response. Some told us they had received supervisions. One staff member described them as useful and good. Other people told us they hadn't received any supervision.

We spoke with one person who worked for an agency for six months when providing support to people on behalf of Liverpool Mental Health Services. During this period they received no supervision from the managers or the provider. When we spoke with the manager about this we were told it was not the provider's responsibility to supervise agency workers. This staff member recently joined the provider and was used to induct and work alongside new staff members. At the time of our visit we were told this person had received no supervision.

Other staff had not been consistently inducted. One staff member told us that somebody had "Been through the induction file with me". However, the induction booklet in their file was blank. One staff member told us they had no induction or shadow time. They described how on their first day they were providing support to people alongside an agency worker. On their second or third working day they were introducing a new person to people on their first day. Both of these staff were not trained in the administration of medication. An agency worker who was medication trained but had never met people and the two new staff

administered medication together. The staff member said "I was thrown in".

In two staff files we looked at the 'Induction Programme' booklet was blank.

The manager told us they had what they described as a 'staffing crisis'. They were in the middle of a recruitment drive. During the second day of our visit we observed one new member of staff who was shadowing another support worker. We spoke with them and they told us they were meeting all the people supported this week during their week of shadowing.

New staff had not received important training in a reasonable timeframe. Some people had a record of training received, others had received insufficient training to equip them for their role.

We found there had been a failure to have suitably competent, skilled and experienced care staff for people with complex mental health needs and presentations, exposing service users and staff to the risk of harm.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. People did not receive appropriate training.

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 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.

There were no restrictive practices observed in the support of people by Liverpool Mental Health Services. However in regard to consent, the provider failed to act in accordance with the requirements of the Mental Capacity Act 2005. This was in relation to the refusal of medication that was important to a person's mental health over a period of weeks. The provider had failed to make an assessment of the impact this may have had over a period of time on the person's ability to give consent to their care and treatment. The support given to a person who had refused their medication and the actions taken by the provider were not recorded sufficiently in order to provide effective care and support.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Failure to obtain lawful consent and follow the requirements of the Mental Capacity Act 2005 exposed people supported to the risk of harm.

People told they were supported to see medical professionals for periodic appointments and when they needed to. If necessary support was provided for people to attend appointments or they attended with family members.

Requires Improvement

Is the service caring?

Our findings

One person we spoke with told us they had "Got good staff here that look after us". Another person told us "I can't fault our staff".

One staff member told us the best part of the job was helping people "Making a difference, some people have gone from being low to feeling better". One person had completed a work placement with the provider and stayed on afterwards as a volunteer. They told us they really enjoyed the role especially when they were able to work out what somebody really enjoyed.

Some of the people supported made a distinction between temporary staff who came and went, and the regular staff. One person told us how two of the staff had come to see them in hospital in their own time out of concern for them.

We witnessed one person being reassured with caring and patience over a stressful situation. We found the staff providing people with support had a regard for people's wellbeing. This was evident in their approach.

A dignity tree was made on the wall in the lounge to celebrate 'dignity action day'. People were encouraged to write on one of the leaves what dignity meant to them. Some of the leaves read 'Being treated like an equal and with respect.' and 'Being respected and listened to'. People supported and staff told us that people had enjoyed exploring what dignity meant to them. One person we spoke with told us, "I'm treated with the dignity I'm entitled to".

One person told us how they had been involved in the recent recruitment drive as the 'tenant representative'. They attended the interviews and asked questions on behalf of the people living in the flats. He scored the person after the interview which fed into the overall score. The person was very positive about this.

Another person told us that he didn't like the phrase 'service user' when staff spoke about the people living in the flats. He told one of the senior staff about this and was asked what he thought would be a good term to use. The person said "tenants" as this more accurately reflected the relationship between the staff and the people supported. This was adopted by the manager and the staff. The person was listened to and changes made.

One professional told us they had been impressed with staff support and their efforts to build up a relationship and trust with a person supported. They had supported them a lot and helped to work through difficult problems.

We found that people hadn't always been involved in planning their care. There were occasions when there was not adequate support for people in terms of offering information and explanations to people.

Although people's interactions were caring. At times there was not adequate organisational steps taken to

care for a person's wellbeing. Examples of this were not following up on refused medication and making sure a person had the capacity to make decisions affecting their wellbeing.

Requires Improvement

Is the service responsive?

Our findings

One person told us they had been supported by the agency for two years and it had been good. They said "I get supported with my needs every day". Another person said "The staff help me with anything I want them to do".

We asked people what they thought could improve with their support. One person said they would like people to have "more experiences, help people with the real world".

We asked one staff member if they though people's support plans accurately documented people's needs and they replied "not always".

For many people the support was 'background' support of having staff members on site accessed when a person needed it. One person told us, "I like the support in the background; I like to know it's there". People came and went from their flats as they pleased. Some people were involved in their community. One person we spoke with told us they volunteered with a local education focused organisation. Other people, because of their support needs, chose not to go out without support from staff, family members or friends.

One professional told us the provider could monitor the care needs and welfare of people more. They considered that the support, advice and the mitigating of risks was inconsistent. Another professional told us that the staff tried to organise one to one time around what the person wanted.

People's files we looked at contained a lot of information about the person. These were written in a way that was person centred and had been updated frequently. We observed examples of how at times these had been effective in guiding the support of people and responding to their needs. However this was inconsistent and there were other times when they had not been effective in guiding the support to respond to people's needs.

It was difficult to see how people's support plans guided support staff in their day to day role and provided them with focus to ensure people's needs were met. Staff we observed seemed to either be responding to the next thing happening or being led by a schedule that didn't highlight the main reasons for a person's support. One person told us they thought "Some other people got more attention, get quicker attention, I resent this slightly".

We noted that people's informal complaints that they had raised had been listened to and changes had been made.

Some people required intensive support to maintain their tenancy, some people a little help at times and other people were independent. People told us, "At times I get help to tidy my flat, I accept it, often don't need it". Another person told us they were able to "keep my own house in order". We found the staff responded appropriately to people's varying needs in this area..

There had been recent art workshops in the communal areas organised by the staff. People's paintings were displayed on the walls. One staff member told us it was difficult to get people motivated at first but eventually it was a success and was ongoing. One person showed us their art and said "painting helps me". Some people had painted motivational quotes and peaceful scenes.

The staff had also arranged cooking sessions in the communal kitchen area. The landlord had a chip pan amnesty where people could receive a new electric air fryer in exchange for an old chip pan. The staff organised for people to get familiar using the new fryers in the communal kitchen and held a chip butty night as an opportunity to socialise.

Staff had arranged for people who wished to, to spend Christmas day together. This included a full Christmas dinner that people got involved in cooking. Everybody we spoke with told us they really enjoyed spending Christmas together. One person told us "It was lovely, went perfect, I cooked the turkey".

One staff member told us, "People only come down and use the communal areas if we organise something. We had a movie night at New Year. Christmas day was really great, we had the full table set up and crackers and everything. There was a great atmosphere".

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place, however we were informed that a manager application was in progress. People we spoke with did not know who the manager was.

There was a mix of opinion from people supported as to the quality of the leadership of the organisation. One person told us "There is no communication". They added they thought the management was poor. Another person told us that one of the senior staff kept people on their toes.

One staff member told us, "Sometimes I feel the management are all over the place." They described how there could be conflicting advice from senior members of staff. Another staff member told us the managers were quite good, but said it could be confusing "who to go to for what".

The area manager and team leader were both quite new to the service. They said the service had been very short staffed but they had taken steps to address this problem by recruiting new staff and reducing the use of temporary staff.

There was a lack of involvement by the managers in inducting and setting the culture for the new staff. We found examples of inexperienced staff introducing new staff, leading them to follow the previous person's practice. For example, the incorrect use of medication records had been passed on from one staff member to another. The team leader did not take this opportunity to embed the practices and culture they wanted on an inexperienced team.

We found that audits and assessments of the support provided had not been effective.

The senior support worker undertook weekly medication audits. A weekly medication audit was in place and we observed these in some people's medication files. However, on one person's medication file the past three weeks audits were missing. This was for a person with a history of difficulties in administering their medication.

Information gathered from the medication audits had not led to incident forms being completed. The medication audits were not effective in improving the safe administration and recording of medication. The inaccurate and inconsistent completion of records was not addressed by the audits.

The policy relating to medication errors was not followed and errors had not been reported in accordance with the policy.

The provider had a computer based incident recording system and also kept a file of incident and accident reports, this was organised and indexed. The file contained copies of any incidents that had led to notifications to the CQC and safeguarding alerts to the local authority. However there was no evidence that the information gathered was used to look for patterns or to mitigate any risks identified. When we spoke to

the provider about this we were told that there was an error on the computer system which meant that the local team leader was not getting copies of the incident reports. The provider's policy on 'accident and incident reporting' states that area managers, service managers and team leaders should, 'Monitor trends within the area of responsibility' and 'contribute to dissemination of lessons learned and implementation of improvement actions'. The audits failed to assess and monitor the risks relating to the health and safety and welfare of people using the service and to mitigate the risks in relation to their health, safety and welfare.

We observed poor and inaccurate contemporaneous record keeping, in particular in relation to people with particular support needs. This had contributed to members of staff not knowing what medication a person was due to be administered and what support had recently been offered to a person by support staff. There was a number of days missing from the daily contact sheets and contradictions between these records and medication administration records.

Staff had access to policies in the office and could access them on the staff computer. We found that the senior staff and the support staff did not follow policies consistently.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of Good Governance that had
exposed people using the service to the risk of harm.

We found that senior staff were open and receptive to our comments.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to obtain lawful consent and follow the requirements of the Mental Capacity Act 2005 exposed people supported to the risk of harm.

The enforcement action we took:

We raised a section 31 notice of decision to restrict admissions to the accomodation based at 3 Devonshire Road, Liverpool.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The administration, recording and storage of medication was not safe. Risks to people's health and wellbeing were not consistently assessed.

The enforcement action we took:

We raised a section 31 notice of decision to restrict admissions to the accomodation based at 3 Devonshire Road, Liverpool.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of Good Governance that had exposed people using the service to the risk of harm.

The enforcement action we took:

We raised a section 31 notice of decision to restrict admissions to the accomodation based at 3 Devonshire Road, Liverpool.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. People did not receive appropriate training.

The enforcement action we took:

We raised a section 31 notice of decision to restrict admissions to the accomodation based at 3 Devonshire Road, Liverpool.