St. Mary's (Dover) Limited

St Mary's

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced inspection of this service on 27 July and 2 and 9 August 2017.

St. Mary's is a large detached property providing residential and dementia care for up to 36 older people. The service is located within the town of Dover. Residential accommodation is situated over four floors. There is a separate unit to support people living with dementia. The service also has its own chapel and a garden to the rear of the property. At the time of inspection there were 21 people living at the service.

This service did not have a registered manager in post. The previous registered manager left the service in April 2016. At the previous inspection the provider told us that they were in the process of appointing a new manager but this had not been done. A registered manager from the provider's other location was supporting the service two days a week and there were two deputy managers in day to day charge of the service. The two deputy managers supported three inspectors during the first day of the inspection. A registered manager is a person who is 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 last inspected this service in January 2017. We found significant shortfalls and the service had an overall rating of requires improvement with an inadequate rating in the well led domain. The service had been rated 'inadequate' overall at our inspection in August 2016 and been placed in special measures. As the provider remained in breach of the regulations and there was a lack of leadership the service remained in special measures which required the provider to make improvements. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The provider sent us information and records about actions taken to make improvements following our previous inspection.

At this inspection improvements had not been made and the provider had not complied with all of the requirement notices issued at the previous inspection in January 2017 and further breaches of the regulations were found at this inspection.

The provider had failed to comply with a condition we had applied to their registration requiring them to appoint a registered manager. Although some efforts had been made to register a manager and an application had been sent to CQC this was subsequently withdrawn.

The systems in place to audit the quality of the service were not effective. The provider had not ensured that the requirement notices issued at the previous inspection were complied with. There remained continuous breaches of 5 regulations and 6 further breaches of regulations were identified at this inspection.

Whistle blowers had contacted the Care Quality Commission to inform us that staff were getting people up

in the dementia unit from 5 am onwards. We arrived at 7 am; four people were up in the dementia unit and two people were up in the residential unit. Action had not been taken to address this concern and to make sure people had the choice of when they wanted to get up.

People were not protected from harm as the provider had failed to take action to ensure people were safe and report safeguarding issues to the local authority.

Risks to people's health when they fell were not being mitigated and there continued to be a lack of risk assessments to guide staff how to support people safely. People were at risk of choking however, detailed risk assessments were not in place to ensure that staff had information to support people with their meals and drinks.

People sometimes displayed behaviour that challenged and were at risk of harming themselves or others. The deputy manager had implemented behavioural risk assessments to give staff guidance on how to positively support people with their behaviour. However, the assessments lacked information on what may trigger the behaviours and how to reduce the risk of them happening again.

The premises were not being routinely maintained to provide a safe and comfortable environment. The provider had not acted in a timely manner to ensure the repairs and maintenance were carried out to ensure the environment was safe. The garden had not been maintained.

Equipment to support people with their mobility had been serviced to ensure that it was safe; however staff told us one there were issues with a battery on one hoist which was not charging properly. The deputy managers were aware of this but no action had been taken to resolve this issue.

Pressure relieving equipment had not been checked to confirm it was set to the individual setting for each person to reduce the risk of pressure sores.

Concerns were raised with regard to the telephone system not working as this was having an impact of how staff were managing the service. There was limited access to the internet to send and receive emails and the printer was not working.

Accidents and incidents were recorded; but further action had not been taken to ensure the service learnt lessons for the continuous improvement of the service. There was a summary of events but no further analysis had been carried out to identify any patterns or trends, to prevent further occurrences.

Staffing levels were not always sufficient to ensure people received the care they needed. The deployment of staff needed to be reviewed so that sufficient staff were on duty at all times. Staff had not been recruited safely to ensure they were suitable to work at the service.

Medication was not being safely managed or stored securely. Referrals to health care professionals had been made but not followed up to ensure that people were getting the professional guidance and support they needed.

Applications to apply for authorisations to deprive people of their liberty in line with the Mental Capacity Act had been applied for, but in one instance staff had not recognised that a person's liberty was being restricted.

People told us the food was good and they had enough to eat and drink. The four weekly menus needed to

be reviewed as at times the meals were repetitive, such as for four days in a row the main meal was beef and mince. The provider had not ensured that people and staff had the necessary supplies of food and gloves to ensure people received safe and effective care. On occasions the shopping had arrived late and the service had run out of milk and bread. At the time of the inspection they also run out of tea bags and the deputy manager gave a member of staff some of their own money to go to the local shop to purchase a supply.

The provider had not ensured that bed linen and some towels were fit for purpose or suitable for people to use.

Staff interaction was kind and caring but there was a lack of contact from staff when people remained in their rooms. People's privacy and dignity was not always maintained when incidents occurred in people's bedrooms.

Care plans were not person centred or detailed enough to ensure consistent care was being provided. When reviews had taken place, in some cases, staff had recorded incidents that had occurred but no action had been recorded. The care plans and risk assessments had not always been updated to reflect people's current needs.

People were not being supported to follow their interests and take part in social activities of their choice. There were no dedicated activities co-ordinator and activities were limited.

The system to monitor complaints was not effective as complaints had not been recorded. There were no records to show that complaints had been investigated and satisfactorily resolved.

Staff and relatives told us that they thought the care being provided was good but the service was not well led as the provider lacked leadership skills.

The service was not being supported by the provider to ensure that people were receiving safe and effective care. There was a lack of leadership and oversight of the service. The deputy managers in day to day control of the service lacked autonomy, support and skill to be able to manage and provide the service.

The audits carried out by the deputy managers were not effective as they did not identify the concerns raised at this inspection. The provider had visited the service twice in the last six weeks and no formal checks had been made on the quality of care being provided.

Checks on the fire system had been made on a regular basis and fire drills had been completed. There was a personal evacuation plan for each person and an emergency procedure in place. Not all staff had received the fire training they needed to safely evacuate people from the premises.

Since the previous inspection only staff had received a quality assurance survey which was in the process of being collated. The results of the survey last year had not been acted on or summarised or shared with people.

A whistle blower told CQC that there were continuing issues with their wages and mistakes were still being made. They had raised these concerns with the provider who assured them this would not happen again but errors were still occurring.

Although some improvement to records had been made, there remained areas where records were inconsistent and not accurately completed or secure, such as care plans, night checks and accident forms.

Staff told us they were loyal to the people who lived at the service as many people had lived there for several years. They said that improvements to the service were slow but new staff had been recruited which had helped improve their morale. There were concerns about keeping their jobs, the lack of gloves and having to purchase items like food, for the service.

There was an ongoing training programme in place to ensure that staff had received the required training. Staff had received individual supervision and an annual appraisal to address training and development needs.

People's finances were protected as there were systems in place to record and check all transactions.

Other safety checks had been carried out on the premises, such as the gas safety certificate; portable electrical appliances, and lifts.

We identified a number of continued breaches of regulations and additional breaches. The service will therefore remain in special measures. We will continue to monitor St Mary's to check that improvements are made and are sustained. 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 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.

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.

People were not protected from harm as the provider had failed to take action to ensure people were safe and report safeguarding issues to the local authority.

Risks to people's safety and behaviour were not always managed. Staff did not always have the guidance to support people safely.

Accidents and incidents had been recorded but further analysis was required to keep people safe and to reduce the risk of further events.

The management and storage of medicines was not safe.

There was not always enough staff on duty to meet people's needs and staff were not recruited safely.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have a full awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards as they had not recognised when people's liberty had been restricted.

People had access to health care professionals when needed, however referrals had not been followed up to ensure people were receiving the professional advice they needed.

People received enough to eat and drink to support them to remain as healthy as possible.

Staff had received training, supervision and appraisals to support them in their role.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people with respect however, the provider had not treated people in a respectful way..

People were encouraged to be independent where possible and were given choices about their care and support.

People and relatives told us that the staff were kind and caring.

People's personal information was not always stored securely.

Is the service responsive?

Inadequate

The service was not responsive.

People's care was not personalised to ensure consistent safe care was being provided. Although care plans were regularly reviewed the information was not always updated to reflect people's current needs.

There was lack of meaningful activities and no formal programme to ensure that people were able to maintain their hobbies and interests.

Complaints had not been recorded and complaints had not been investigated and resolved, or responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not appointed a registered manager to improve the leadership of the service.

The provider had not taken appropriate action to ensure the service was compliant with the regulations.

The systems for monitoring and checking the quality of care provided were not effective as the shortfalls found at this inspection had not been identified and actioned.

People/relatives and staff views were not taken into account to continuously improve the service.

Records were not always accurate or up to date.

St Mary's

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection of this service on 27 July 2017 and visited the provider on 1 August 2017 and 9 August 2017. The inspection was carried out by three inspectors..
We spent some time talking with people in the service and staff; we looked at records as well as operational processes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by whistle blowers, relatives, visiting professionals and a member of the public. On this occasion the provider had not received a Provider Information Return (PIR) to complete. 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 gathered and reviewed information about the service before the inspection, including previous inspection reports and notifications. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed a range of records. This included eight care plans and associated risk assessments and environmental risk information. We looked at four staff files, their recruitment, and training and supervision records, in addition to the training records for the whole staff team. We viewed records of accidents/incidents, complaints information and records relating to some equipment, servicing information and maintenance records.

We viewed policies and procedures, medicine records and quality monitoring audits. We spoke with 10 people, 3 relatives, 5 five staff, and the two deputy managers. We spoke with the nominated individual, a director of the provider's company and the registered manager from the provider's other service.

At the previous inspection of this service in January 2017, there were continued breaches of regulations and

CQC took enforcement action. At the time of this inspection there were 5 continued breaches and a further 5 breaches were identified.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe with the care they received from the staff. They said, I came to live here to feel safe and I do." "I don't call staff much, but feel safe knowing that they are there." "The staff help me so that I am safe."

At our last inspection in January 2017 the provider had failed to make sure that risks to people, staff and others had been managed to protect people from harm and ensure their safety, and had failed to make sure that care and treatment was provided in a safe way. The provider sent us an action plan telling us how they were going to improve.

The deputy managers, who were in charge, had a lack of awareness and insight about their responsibility to report safeguarding incidents to the local safeguarding team and to the Care Quality Commission. We found two incidents recorded which had involved people in potentially abusive situations. The deputy manager and staff had sought immediate medical assistance for people but had not followed procedures by consulting with the local authority safeguarding team who would have discussed and assessed the incidents. A decision would then be made on how to proceed to keep people safe in the way that suited them best.

Staff were aware of the whistle blowing policy and knew they could take concerns to agencies outside of the service if they felt they were not being dealt with properly. This had occurred as we received information about poor care practice from two anonymous whistle blowers prior to the inspection.

The provider had not taken action to ensure people were protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Risks to people had been identified and assessed but guidelines to reduce risks were not always followed to ensure people were safe. One person had an unwitnessed fall and fractured their neck. They had been admitted to hospital and were receiving treatment. Staff and the deputy managers told us they believed the person had fallen during the night, but were uncertain when the person had fallen or how long it had been before they received assistance.

Staff had identified the person was at risk of falling and had recorded that the person 'did not alert staff to falls or incidents that occur.' The person's mobilising risk assessment, dated 14 January 2016 and updated 11 February 2016 stated, 'Pressure mat to be placed on floor (right) side of bed at all times' and, 'Monitor half-one hourly during night hours or when in bed' to help manage this risk.

We reviewed the night checks for this person on the night they allegedly fell and staff had checked them every two hours, instead of hourly, as per their assessed need. The alarm sensor in the pressure mat, which was meant to have been placed by the person's bed, had not gone off during the night. One member of staff told us, "Sometimes it is by the bed and sometimes by the door. [The person] is self-caring so staff may put it

at the end of their bed so they can go to the toilet." One of the deputy managers told us, "We had an incident with [another person] so we put it [the mat] outside of the door." Staff had not followed the guidance provided to ensure the person received safe care and was protected from the risk of falls. There was a risk the person had been left for an extended period of time with a fractured neck and had not received timely medical assistance.

Neither the deputy managers nor the provider had not carried out any of kind of investigation or completed any analysis of this incident so were unaware that staff had not followed the guidance provided. They had not recognised the seriousness of this incident and had not discussed it with the local safeguarding team or reported it to the Care Quality Commission, as required by law.

Some people were at risk of choking. There had been incidents in the past where people had choked and staff had called an ambulance and sought immediate medical attention. One person's care plan stated, 'Since incident [where person had choked] they must not be left on their side, in their bed, on their own.' Staff had requested that the person be assessed by a Speech and Language Therapist on 20 February 2017, which was six days after the incident, but had not followed this up. The deputy manager told us they had made the decision that the person should not be positioned on their side. They told us, "I think the district nurses said they shouldn't be on their side too" but there was no evidence that this advice had been given.

Staff were unaware that the deputy manager had decided that the person should not be placed on their side. One member of staff said, "They [the person] were on their side just now." Turn charts for the person showed that they were routinely placed on their side each day so there was a risk the person was not receiving the right support and was at continued risk of choking..

There was no guidance available for staff about what to do if a person choked. We spoke with staff who told us conflicting information about what they would do if this occurred. One staff member told us, "I don't know, that is a scary thought." We asked for clarification and they then said, "Maybe I would slap them once or twice and then call an ambulance." Another staff member told us, "I would lean them forward and pat their back. Just one firm slap." This lack of knowledge and understanding left people at risk of harm.

People's pressure relieving equipment was not always set to the correct settings for their build and weight. Some people were sitting on pressure relieving cushions in the dementia lounge to reduce the risk of developing pressure sores. One person's was set to '9', the highest setting available and they were small in stature. We asked staff if this was correct setting for the person. One staff member said, "I have no idea, no one has ever shown me." Another staff member said, "I am new here, I am on my induction."

Although staff were checking that people's pressure relieving mattress were working, they had not been checking individual settings to ensure they were correct. One person was unable to be weighed so staff had attempted to measure the person's body mass index (BMI). There was no correlation of how this information helped determine the correct setting of the person's airflow mattress which was set at 90 kilograms. Another person's mattress was set at 60 kilograms and the person's last recorded weight in July 2017 was 37.6 kg. Staff were unable to confirm if this was the correct setting and they said they would need to check with the community nursing staff. Incorrect settings can increase people's risk of developing a pressure sore.

The deputy manager told us that one person was known to change the settings on people's pressure relieving equipment. However, this risk was not recorded anywhere and no action had taken to prevent this from occurring. The correct settings for people's pressure relieving equipment was not documented anywhere so no one was able to tell us what settings people's cushions should have been on. There was no monitoring to ensure that the settings remained constant throughout the day. We asked the deputy

manager to speak with the district nurses about what settings equipment should be set to and to email us confirmation that this had been done after the inspection. We did not receive this information.

Risks relating to people's mobility were in place and their care plans contained detailed risk assessments and guidelines relating to people's mobility, their risk of falling and their ability to use a call bell. The deputy manager had written personalised guidelines for each person so staff were aware how to support people if they needed to use a hoist or bath chair. One person said, "The staff know how to move me, they know what they are doing with the hoist." However, there were concerns that one person was no longer able to use the standing hoist and was now using a full hoist. This information had not been updated in their care plan and the risk assessment had not been updated with new guidance to ensure they were being moved safely.

In June one person had eaten a bar of soap and was taken to hospital as they had become unwell. Although the deputy managers were aware of this incident they had not taken action to ensure that other items that should not be eaten were stored securely so there was a risk that this could happen again. The deputy managers had not reported or discussed this incident with the local authority safeguarding team, even though the person had become unwell. We asked them to speak with the local safeguarding team, and an alert was raised after the inspection.

Staff were aware of the person who ingested the soap, however prescribed creams, including diprobase and zerobase were not all locked away securely. We found creams out on the side in some people's bathrooms. These bathrooms were unlocked and freely accessible to people in the dementia unit. There was a risk that people who were confused may apply these creams or ingest them.

The provider had failed to ensure that risks were managed or mitigated. The provider did not have sufficient guidance in place to safely support people with their mobility or behaviour. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was mixed comments from people and staff about the number of staff on duty. They said, "I think there is enough staff at night, but not always during the day, could do with another one." "The girls are kind and caring but don't always have enough time to spend with me."

The deputy managers confirmed that there should be two senior staff members on duty each day; at the time of the inspection one senior member of staff was on annual leave and had not been replaced. There was a new member of staff who was scheduled to shadow an established staff member but they were counted as part of the number of staff on duty. Staff told us that they' just managed' when the staff were not replaced. They said that the two deputies would come out and help them on occasions.

Staff told us that they were some occasions when they were short staffed. We could not tell from the rota when these occasions had occurred as it was not accurate. The names of the staff were written in a diary each day showing who was working on the residential side and in the dementia unit. This was not clear and staff told us that this rota was not followed as it was often inaccurate. They said the diary was not clear and would not reflect the staff on duty. There was no clear rota to check when unavailable staff had or had not been replaced and who was on duty and when.

The entries in the diary stopped on Sunday 30 July 2017.. There was no further rota. The deputy managers told us that staff who were permanent knew their working hours as there worked a two week rota. Other staff without a permanent rota did know what shifts they would be working after 30 July 2017.

Staff were not deployed efficiently. There were three domestic staff on duty during the week and none at

weekends which had an impact on people as care staff had to give people their breakfast and also make sure any domestic tasks were completed. Staff told us, "The domestics tend to do breakfast but not at the weekends. More staff would take the pressure off."

The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always recruited safely. Full recruitment checks should be carried out before staff start work to ensure there is no known reason they should not be working with vulnerable people. One person told us they were, 'on their induction' and were providing support to people. The deputy manager said they had not seen and could not provide evidence that the staff member had been checked by the disclosure and barring service (DBS) to ensure they were safe to work with vulnerable people. The registered manager, from the provider's other service, confirmed after the inspection they had seen this check but did not produce it. Another staff file did not contain any proof of the staff member's identity. The deputy manager told us they had asked to see this staff member's photographic ID on multiple occasions but this request had not been fulfilled. The staff member was able to provide a copy of their photographic ID during the inspection, but had been working with people unchecked for the past four months. A third member of staff had not provided a full work history so any gaps could be checked. The deputy manager told us, "We are going back and discussing the person's work history. It is difficult."

New staff had not been recruited safely and in accordance with Schedule 3 of Regulation 19. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all medicines were being stored securely. People had locked cabinets in their bedrooms to store medicines such as creams, however, prescribed creams had been left out and not locked away to reduce the risk of inappropriate use. The medicines fridge was broken and did not lock. The fridge was located in the staff office, which remained unlocked throughout the inspection. There were 10ml chloramphenicol eye drops and 30g of dakacort cream stored in the fridge, so this was freely accessible to any visitors or people who lived in the main area of the home.

On the day of the inspection, one person went out for lunch; they had lunch time medicines prescribed but were not given this medicine to take with them . There was no guidance for staff about how to manage the administration of these medicines when the person was away from the service. When asked about this the deputy manager told us that staff would go out to the person with the medicines today and a management plan would be put in place for future visits.

Some people were prescribed medicines on an 'as and when' basis such as pain relief. There was no guidance for staff about when these medicines should be given, how often and the time required between doses. We observed people being asked if they needed pain relief during the medicines round.

During our inspection, there was only one member of staff competent to administer medicines on duty; they also were responsible for answering the only telephone for incoming calls in the service. The telephone rang several times and on three occasions the senior staff member had to stop giving people their medicines to find the deputy manager. There was a risk that that people would not receive their medicines in a timely manner.

The provider had not ensured the proper and safe management of medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008

People were given their medicines in the way they preferred, with the drink they liked. Staff had guidance regarding the application of creams, staff signed records to confirm that the cream had been applied. The temperature of the fridge and room the medicines were stored in were recorded daily. When the room temperature was above the recommended temperature for storage of medicines, 25 degrees, an air conditioning unit was used to reduce the temperature.

Staff were trained in how to manage medicines safely, only staff who had been assessed as competent administered medicines.

Whistle blowers told us that on occasions there were not enough gloves for staff to use when providing personal care. We were told by the staff that the deputy manager would use their own money to purchase gloves from the local shops. Other staff told us that they sometimes brought their own gloves to work so that they have the equipment they need. Staff said, "Protective personal equipment (gloves) is horrendous. I have bought my own - I bring my own because I never know if they have any." "It [running out of gloves] normally happens on the weekend so we go and buy our own." "I feel embarrassed to say we do not have any gloves."

The provider was aware of the shortages and was able to demonstrate that orders for the gloves were processed, but no analysis had been carried out to identify how many times staff ran out of gloves and what action needed to be taken, such as increasing the order to make sure there was enough gloves at all times. On the day of the inspection, although there were gloves in the service, there was no additional stock. The deputy manager told us that an order was being processed.

At the last inspection in January 2017, staff told us that a team of three decorators were due to start a programme of refurbishment within the next few days. At the time of this inspection some improvements had been made to the premises, such as painting and decorating; however no repairs had been carried out in the service for the last six weeks. The deputy manager told us that they had appointed a handyperson but they had not turned up to take the position. On the first day of the inspection we found a broken, leaking toilet and the telephone system had not been working for six weeks. We told the deputy managers to take action and the handyman from the provider's other service visited the service immediately. However, when we returned on 2 August these issues still remained and had not been fixed appropriately.

The deputy managers told us that they had to get permission from the provider to effect repairs which led to delays. There was no petty cash in the premises for them access for any immediate jobs or supplies.

The provider had failed to ensure that the premises were protected from the risk of fire. The fire door in the lounge in the residential unit was in need of repair. A maintenance team came on the day of the inspection and fitted a new door guard; however the door did not close properly. We asked the provider to speak with the fire and rescue service for advice. The fire and rescue service visited after the inspection and a schedule of work was issued to repair some of the fire doors in the premises.

Some areas of the premises were in need of painting and this had occurred on the second floor however, the curtains had not been put back up. The shower on the second floor was not working, the deputy manager told us that the shower head needed descaling but there was no record of this and staff told us the shower was not being used. This shower was out of action at the last two inspections so people did not have the choice of a shower.

Whistle blowers told us that there was a problem with the lights on the second floor. At the time of the inspection they were working with one flickering light on the first floor corridor.

Downstairs in the dementia unit near the laundry room, there was a corridor with a glass roof which was in need of repair and the wood on the windows was in a poor state. The deputy manager said that the provider was aware for these issues but there was no record to confirm this and this area was not included in the redecoration/maintenance plan.

The provider had failed to ensure that the premises and the equipment within the premises was safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Checks on the fire system had been made on a regular basis and fire drills had been completed to ensure they had a clear understanding of what action to take in the event of a fire. There were plans in place in case of emergencies, and personal evacuation plans had detailed information on how to evacuate people safely from the premises. The deputy manager told us that some staff had received training on how to horizontal evacuate people but not all staff had completed this training, however only basic fire training had recorded on the training records.

The manual hoists, lift and electrical systems had been serviced to ensure the premises were safe.

There were systems in place to ensure that people's finances were protected. Records showed that people's monies were clearly accounted for together with receipts of all transactions.

Inadequate

Is the service effective?

Our findings

At the previous inspection in January 2017 people were at risk of being restricted unlawfully as staff did not have a clear understanding of deprivation of liberty, in line with the Mental Capacity Act. The provider sent us an action plan telling us how they were going to improve.

At this inspection there remained a lack of understanding as staff had not recognised that a person's liberty was being unlawfully restricted.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible people make their own decisions and are helped to do so when needed.

When people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The provider had not followed the principles of the MCA.

Staff had received MCA and DoLS training, but had failed to recognise when people's liberty was being restricted. One person was being restricted and staff had not recognised this. They were aware that the person did not have full access to the service as there were two locked doors outside of their bedroom preventing their access. When we highlighted to staff that the person was locked in this area, they said, "Technically I guess they are. They broke the door by yanking it." "Yes the doors are locked but they can kick one of the doors open." "This person does their own thing." The provider had not taken advice from the DoLS service at the local authority or applied for a DoLS authorisation.

The provider has failed to ensure that staff were working within the principles of the Mental Capacity Act (2005). This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

Staff had an understanding that when people lacked capacity to give consent that meetings would be held by professionals, including their family to show how decisions about their care had been made.The deputy manager told us that they had applied for DoLS authorisations for some people but these had not been authorised.

People's health care needs were not always monitored to ensure they received specialist support in a timely way from health care professionals. Staff did not always seek advice from health care professionals when people's health needs changed or deteriorated. We found instances where people lost weight and no advice had been sought from dieticians or other health professionals. Some people had experienced choking episodes and although staff had made initial referrals to speech and language therapists (SALT) regarding

their swallow these had not been followed up. Some people had been waiting over five months and had not seen a professional regarding their choking risk. Records showed that doctors had attended the service and people told us that the staff called the doctor if they were not very well. One person said, "The staff call the GP when I am not well" but the risks to people increased because of the lack of follow up by staff of referrals.

We found multiple instances when people had lost weight and staff had not taken action to ensure they were referred to appropriate healthcare professionals. A health care professional could help staff identify why the person was losing weight and offer recommendations on how to help people to sustain healthy weights. One person was documented as having lost 7.4kg in a month. The deputy manager had identified that this weight loss was substantial and had written, '[The person] has a poor appetite and lots of antibiotics for infections but this seems a very large weight loss – to reweigh next week." No further action had been taken and the person had never been reweighed. We raised these concerns with health care professionals after the inspection and the person's weight was reviewed. They were then referred to a dietician.

The provider had failed to ensure that people received safe support with their healthcare needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008.

People told us that they thought the staff were well trained. One person said, "The staff know what they are doing."

Staff were receiving the basic training they needed to support people with their care needs, such as moving and handling, health and safety, first aid, food hygiene, fire and infection control. Updates to ensure staff were aware of current practice were completed when required. Senior staff observed the staff competency when staff were administering medicines but there were no other observational competency checks in other areas.

New staff received an induction and shadowed established staff to observe their practice and become familiar with the needs of the people living at the service. One new member of staff had not completed their full induction training, including safeguarding training, but was working as part of the permanent team rather than an additional staff member to allow them to observe and learn.

Staff received support during formal one to one meetings with their line manager. They discussed issues that had happened in the service and reflected on their practice.

People told us they enjoyed the food, they said, "The food is fine, but sometimes there is not always an alternative I like." "I enjoy the food, it is good, there is always enough to eat." "There is always plenty of food, I am never hungry." "The food always looks good, but I only have a small appetite." Staff asked people if they needed any more and if they enjoyed their lunch.

The meals served at lunch time looked appetising and people had a choice. The daily menu board in the dining room displayed the day's menu and showed two options for each meal. People and staff chatted as they ate their meals and staff provided them with drinks of their choice. We overheard staff asking people what they would like for breakfast, they said, "Good morning [the person] would you like cereal, or would you like a change today".

Some people required fortified meals and drinks for people who needed extra nutrition. Staff completed food and fluid charts if people with poor appetites needed to be monitored to ensure they were eating well. After the inspection health care professionals told us that the forms were not completed accurately with

each person's desired fluid intake, they were not being totalled at the end of the day and nutritional supplement drinks were not always recorded.

There was a four week menu which was a repetitive in some areas for example, week 2 showed, Monday, lasagne, Tuesday roast beef, Wednesday minced beef, and Thursday shepherd's pie although there was an alternative each day there was a repetition of beef for four days. The chef told us that they would often change this week to give people more variety.

On the morning of the inspection there was no milk at the service. A relative told us they were upset there was no milk as people could not have a cup of tea. One of the deputy managers went out and bought milk with her own money.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us the staff were kind and caring. They said, "I am happy here, staff come when I call them." "The staff are kind and caring." "I have a good relationship with the staff; we always have a chat and laugh." "Staff always help me and are kind, they don't rush me." "I like seeing the staff and having a chat." "The staff are very kind, I like it here."

Relatives spoke positively about the care being provided. They said, "The care is excellent, the care staff are very good. "The staff are very good". A relative told us " You cannot fault the (care staff), there are no problems with the care aspect, the problems are with senior management."
Staff said "I think the residents are cared for well. We do our best. We need to be able to spend more time with them." "I like working here; we are supported by the deputy manager." "We all get on well as a team." "If my Nan needed care, I would recommend St Mary's."

Before the inspection we received information of concern from a whistle blower that staff had been told to ensure that some people were up and dressed before the night shift had ended. We visited the service at 7am in the morning and four people in the dementia unit were up and dressed. One person was asleep in their chair in the corner. We were told they had been "Up most of the night. At 5am they had a little accident so we washed and dressed them." Staff confirmed that one of the deputy managers had written a note in the communication book asking them to ensure that some people were washed and dressed early in the morning before the night staff went off duty. The deputy manager told us that this had been misinterpreted; however, the note had been removed from the book so were unable to review it.

Although people were up and dressed at 7am they had not been offered any breakfast. An agency member of staff told us, "I haven't been able to give some of the people breakfast this morning as there is no bread." We asked a person if they had been offered anything to eat and they told us, "Not yet." When the day staff arrived at 7:30am we told them that people had not been given breakfast and they found bread in the main kitchen. People were then offered a choice between toast and cornflakes and were supported to eat their breakfast.

In the residential side of the service, two people were up. Both of these people told us they liked to get up early, one was up and dressed in their room whilst the other person was in the communal lounge. People said, "I like to go to bed around 11pm and get up at 8.30am, the staff make sure this happens." "I get up early but I like that." "I like to be up around 8am and the staff usually come in at that time."

People's privacy and dignity had not always maintained. There had been an incident when a person was found inappropriately dressed in another person's room and although some action had been taken to monitor their movements, there was no record of how staff were going to maintain the person's dignity.

Some bed linen and towels were not fit for purpose or suitable for people to use. The sheets were threadbare and the deputy manager took them off people's beds to be replaced and some towels were frayed around the edges.

People's care plans and associated risk assessments were not always stored securely and locked away to ensure that personal information remained confidential.

The provider failed to ensure that people were being treated with dignity and respect. People were not being given the choice or preferences of when to get up in the morning. Confidential personal information was not stored securely. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff made sure that people had a call bell with them when sitting in the lounge and on their table by the bed so they could reach it. However, there were long periods of time when the lounge in the residential unit was left without any staff. People said during these times they were bored as there was no interaction with staff or any social activities.

Staff interacted with people in a caring respectful way and people told us the staff cared for them well.

Staff gave examples of how they supported people to maintain their privacy and dignity. One staff member said, "Give them private space. Make sure doors are closed and that they are covered."

People told us that staff knew them well and they were supported with their daily routines. They told us they had choices such as where they wanted to sit or the clothes they wished to wear. Staff gave people a choice for breakfast, extra drinks were made when asked for. People said, "Staff know me and know what I like, they make sure I am happy." "Staff always ask me what I want to wear in the morning; I have to ask them about the weather to be able to decide." "I like to wear a tie and the staff make sure that I have one to match my shirt."

At lunch time a member of staff noticed that a person was uncomfortable and offered them a cushion for their back, the person thanked the member of staff and settled to eat their dinner. Staff encouraged people to be independent as possible. They were encouraging someone to walk to the bathroom with their zimmer frame, talking to them all the time and then respected the person's decision to use the wheelchair to return back from the bathroom to their chair.

Staff told us how they supported people to remain as independent as possible by encouraging them to do things for themselves, such as washing the parts of their body they could reach. People said, "I can do a lot for myself but I know that the staff will always pop in to see me, make sure I am ok." "The staff help me when I need it and let me do things for myself when I can." "I move between the chair and my bed through the day and night, the staff always help me, at any time."

People were encouraged to help with daily tasks, such as tidying the kitchenette, drying up the cups and replacing stocks of tea bags. Another person enjoyed putting the napkins on the table at lunch time. Staff spoke to people at their level, crouching down and making eye contact. They spoke to people discreetly when asking them if they needed the bathroom. When staff were asked by one person to wait for them whilst they used the bathroom and to remain outside, their decision was respected.

People were happy and relaxed in the company of staff; there was lots of laughter and banter. Staff made sure people felt re-assured and gently gave a reassuring hand on the persons arm or hand. People smiled and became relaxed when staff gave them re-assurance.

One person became distressed; they were visibly upset and crying. One member of staff asked them what was wrong, and the person told them that they were lonely. The staff member spoke to them in a kind way

and offered them verbal reassurance. They told them that they were loved, and that everyone was there for them. The person smiled and appeared calmer following this conversation.

Records showed that people had been consulted about if they preferred a male or female carer and what they liked to be called. People said that when they choose to stay in their bedroom, staff checked to see if they needed anything.

People's religious beliefs were supported. Church services were held in the chapel which was always open if people needed some quite time to gather their thoughts. People used the chapel when they wanted. One person choose to go to their preferred church each Sunday.

If people needed independent support and help to make decisions about their care, local advocacy services were available. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

There were policies and procedures in pace to ensure that staff were aware of how to support people equally taking into account their ethnicity , diversity, culture, religion, gender and any disabilities

Staff told us that they treated people 'like they would want to be treated' and as an individual.

Inadequate

Is the service responsive?

Our findings

Some people were aware of their care plans and relatives had been involved in planning their care.

People said that the staff responded when they called them. They said, "The staff come quickly when I use the bell most times, a little slower at busy times."

People told us they knew how to complain. They said, "I know how to complain but don't feel I need to." "If I am unhappy I will tell the staff and they will deal with it."

A relative told us that if they had any complaints they were sorted out but they had to speak with the supporting registered manager for action to be taken.

At our last inspection in January 2017 the provider had failed to make sure that complaints were recorded and resolved. The provider sent us an action plan telling us how they were going to improve.

At the time of this inspection, improvements had not been made. Concerns and complaints had not been recorded. We were aware of two complaints had been made to the service but there were no records of these complaints in the complaints log. The deputy managers told us that the supporting registered manager was dealing with one complaint from a relative and social services were dealing with another complaint but there were no details of the complaints and if they had been satisfactorily resolved.

The provider did not have an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a continued breach of Regulation 16, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were not personalised to ensure that people received consistent care. One person required bed rest in the afternoon. Their care plan stated, '[The person] is assisted into bed mid-afternoon for bed rest to relieve pressure to their sacral area.' The person was described as very 'sociable' and it was noted that they enjoyed activities such as music and singing. Although the person enjoyed the company of others staff told us that once they had been assisted into bed, they remained there until the next morning. This meant they remained in their room, without any company for most of the day and night. One staff member told us, "They get up in the morning and then go back to bed." The person's care plan did say, 'They enjoy having a video playing in their room. This keeps them occupied for a while until they are ready to go to sleep.' We visited the person in their bedroom and there was no video playing. The deputy manager told us that due to the position of the person's bed and the need to re-position them regularly made the television difficult to see. Staff told us that the person liked to have the radio playing, but the radio had not been switched on.

Records lacked detail to give an overview of people's care. When people required a modified diet staff just wrote, 'puree' for each of the meals they ate. There were delays in responding to people's needs. People's weights were not being monitored effectively. When one person had lost a considerable amount of weight the staff had not responded in a timely manner to refer the person to the dietician for additional support.

Another person needed additional support with their behaviour as incidents of behaviour that could be challenging had been recorded but there was no referral to the local community mental health team for advice or support.

Daily evaluation notes to show what care and support people had received were not always recorded accurately. An incident had occurred during the night when a person went into another person's room. No one was harmed but this incident and what action was taken was not recorded in the daily notes. It was noted on the night checks, 'no concerns during the night checks'. Therefore staff would not be aware of this behaviour and what action they needed to take to manage the risks. On the person's monthly review of the care plan there was no record of this event and the care plan and risk assessments had not been updated to show what action and support was put in place to reduce the risk of this happening again.

Staff had not responded in a timely way when a person was assessed by an occupational therapist and recommend to use a specialist wheelchair. The person was using a standard wheelchair that had been donated to the service. The deputy manager was aware of this but no further professional advice had been sought to ensure the chair was suitable and safe for the person to use.

People were not being supported to socialise or take part in meaningful activities. They said, "I am very bored, there is nothing to do." "I often fall asleep as there is nothing to do." "Mainly watch TV but sometimes there is bingo and someone comes in to play music." "We don't do much; I look out the window or watch TV." "I don't feel like doing much, I watch TV but the reception is poor, which makes it hard.

People had not been consulted or involved in planning any activities for the service. The deputy managers told us that they had tried to employ an activities co-ordinator but this had not been successful. The other activities provided were a monthly music therapy session, or bingo. However, staff told us that the bingo person had not been for a while. Each person had an activity record in their care plans which had not been completed properly. One person liked to venture out in the garden and this was recorded on their care plan, however this had only happened twice in two months.

Staff told us, "We need an activities person." "The residents love music therapy, but it is only every month. I think it should be every week." "We do not have one to one time with the residents. I will try to so some activities but we don't really have the time". Relatives said, "There is no staff to walk my relative around the garden there is such a lack of activities, they said, "It is such a shame, the garden used to be lovely."

The provider was not ensuring that person centred care and treatment was being provided and care plans had not all been appropriately reviewed or updated. People were not being supported to follow their interests and take part in social activities of their choice. This is a breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff responded when they ran out of supplies and there was no petty cash to support the purchase of as and when required items. One person came to the deputy manager's office and was visibly anxious. They were pacing up and down. The service had run out of tea bags and the person was aware of this. the person refilled storage jars with tea bags every day. . No provision had been made to purchase tea bags when staff had noticed they were running low to ensure they did not run out and that people were able to receive drinks of their choosing. There was no money available at the service for staff to use in an emergency or at short notice to make small, day to day purchases so the deputy manager left the service to buy a pack of tea bags with their own money.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Relatives told us that the care staff were very good but the service was not well led. They said, "The care is excellent but the leadership is poor". They told us that the two deputy managers did not have any autonomy to run the service.

Relatives felt that at times too many staff, including the managers, were outside smoking in the garden which left minimum staff in the building to provide safe care. The deputy manager was aware of this issue and told us that action had been taken to ensure staff breaks were staggered to ensure there was enough staff in the units to cover.

At the previous inspection in January 2017 the provider had failed to appoint a registered manager and the service had now been without a registered manager since April 2016. Since this inspection the management structure had changed and the registered manager from the provider's other location was supporting the service two days a week. There were two deputy managers who were in day to day control of the service. The provider told us that they were recruiting for a registered manager position but applicants so far did not have the experience and skills they required for the service. They wrote to the Care Quality Commission on 6 November 2016 advising that the registered manager of their other location would be applying to CQC for registration of both services. An application was submitted but this was subsequently withdrawn, therefore the service remained without a registered manager in post.

The provider had failed to comply with a condition applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager. This is a breach of Section 33 of the Health and Social Care Act 2008.

At our last inspection in January 2017, the well led domain was rated as inadequate the service continued to be placed in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The provider sent us an action plan, however the action plan did not include what improvements had been made to mitigate risks and no information was received about the improvements to records. At the time of this inspection the service had not sustained these improvements and remained in continued breach of regulations, 11, 12, 16, 17 and section 33.

The provider had failed to ensure that they were compliant with continued breaches of regulations, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition 6 requirement notices for regulation 9, 10, 13, 18,, 19 and registration regulation 18 were issued.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action has been taken. One person had fallen and sustained a serious injury and safeguarding incidents had occurred within the service, we were unaware of these events before the inspection. The deputy managers and the provider had not submitted notifications, as required by law, in a timely manner. There had been a number of notifiable

incidents that were reportable and had not been action by the service, such as the incident where the person broke their neck, and person ingested soap.

The provider had failed to notify CQC of notifiable events. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Whistle blowers had contacted the Care Quality Commission and informed us that staff were getting people up in the dementia unit from 5 am onwards, as the deputy manager had recorded in the communications book that staff had to do this. The deputy manager said that this had been misunderstood and people always had the choice of when to get up. Records in the communication book did not show this message as the pages from 17 July to 20 July were missing. Staff told us that this was removed on the instructions from the supporting registered manager. The provider was aware of this message but no action had been taken to investigate these issues to ensure that people had their choice and ensuring records were a true and accurate account of the service being provided.

Staff told us there was a lack of support from the provider and their representatives. The systems to ensure that the service was stocked with the necessary food and equipment were not in place. Staff had raised at a staff meeting on 28 June that the correct food was not always ordered, that there was not always enough meat and there was not enough gloves at the service.

The provider had failed to provide basic provisions. There was no money available to purchase necessary day to day items or items for an emergency. Staff told us that they routinely purchased gloves using their own money when they ran out and we observed the deputy manager having to buy tea bags using their own money during the inspection. They told us, "There are some issues around shopping. If it is not here then I go out and buy it." On the third day of the inspection a relative told us there was no milk that morning so people had gone without drinks of tea and coffee.

At the meeting on 28 June 2017 staff raised that they were not paid the correct amount or on time. The minutes stated, 'Pay roll – wages are sent to the accountant and I have heard there are a lot of issues about this.' Staff told us they were worried about their jobs and confirmed that there were ongoing issues with the wages and at times supplies were short such as the lack of gloves and tea bags. They continued to say that the shopping had arrived late and at times the deputy had to bury bread and milk. A relative commented, "There are little touches that aren't there any more, such as lack of serviettes, white paper rolls and loo rolls."

Staff told us that equipment needed to move people safely had broken and the provider had not taken any action to ensure that it was fixed. There was a lack of charged and working batteries for equipment so staff told us, "We are having to share the battery between two different hoists."

Throughout the inspection we asked to review paperwork relating to people's care and support. There were large piles of paper including people's food and fluid charts, night checks and turning charts kept in two different staff offices and the deputy manager's office which had not been checked and were not stored securely. People who required hourly checks throughout the night were not receiving these and as night check records were not reviewed the deputy managers were unaware of this. The deputy managers were also unaware that a person was being positioned on their side, against the advice in their care plan, even though the staff recorded that this was happening daily.

The deputy managers completed a small number of checks on the service including a monthly check on medicines and regular checks on the environment. The medicines audit had highlighted that the lock on the

fridge had broken and the environmental audit had noted recent issues regarding the broken toilet yet no action had been taken to address these. The provider and their representatives did not carry out any formal checks on the service to ensure it was safe and well managed.

None of the serious issues regarding risk management and the response to incidents that we raised had been identified prior to our inspection.

People and their relatives had not been asked their views on the service since the last inspection. The deputy manager told us that they wanted to implement 'necessary improvements' before asking what they thought. Staff had been asked their views and five staff surveys had been returned. Two of the surveys contained negative statements including, 'We are not supported by certain people within the management team' and, 'Staff wages are not acceptable for the work done within the job role.' For the question, 'Do you feel that the residents at St Mary's are cared for and their individual needs are met?' One staff member had written, 'No.' No action had been taken to address the concerns highlighted in these surveys. The deputy manager had not considered that people could be at risk if staff felt their needs were not being met.

Accidents and incidents had been recorded and the deputy manager had completed a summary however the incidents lacked analysis to look for patterns and trends. The analysis had not picked up that the incident when the person fractured their neck was not reported to safeguarding, CQC or Riddor.

Staff told us that improvements were slow but they did not have confidence in the provider to get repairs and things done in a timely manner.

We met with the nominated individual and a director of the provider's company on the second day of the inspection. They were unaware of the serious concerns we had identified on the first day of the inspection. They had not taken any action to reduce the risks we identified. We shared our concerns with the local authority commissioning and safeguarding teams and they took action to ensure people were safe.

The provider had failed to take appropriate action to mitigate risks and improve the quality and safety of the service and records were not completed fully or accurately. This was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of notifiable events.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider had failed to comply with a condition we had applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager. This was a continued breach of Section 33.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring that person centred care and treatment was being provided and care plans had not all been appropriately reviewed or updated. People were not being supported to follow their interests and take part in social activities of their choice.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people were being treated with dignity and respect. People

were not being given the choice or preferences of when to get up in the morning.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were at risk of being restricted unlawfully as staff did not have a full understating oh how to apply the principles of the Mental Capacity Act. This was a continued breach of Regulation 11, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of risk assessments to guide staff how to mitigate risks when supporting people with their behaviour. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Non -urgent cancellation of registration.

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 provider had not made referrals to the local safeguarding authority to ensure people were protected from abuse and improper treatment.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

	The provider did not have an effective and accessible system for identifying, receiving, handling and responding to complaints. This was a continued breach of Regulation 16, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services and records were not completed fully or accurately This was a continued breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed New staff had not been recruited safely and in accordance with Schedule 3, Regulation 19.

The enforcement action we took:

Non -urgent cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed.

The enforcement action we took:

Non -urgent cancellation of registration.