Lotus Care (Cressington Court) Limited

Cressington Court Care Home

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

Summary of findings

Overall summary

About the service:
Cressington Court Care Home is a care home that was providing personal and nursing care to 44 people at the time of the inspection. It is registered to provide a service to older people who may be living with dementia and/or physical disabilities.

People's experience of using this service:
People were not always treated with care and compassion and were sometimes left in undignified situations.

The service was not acting in line with the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. This meant that people were at risk of having their liberty unlawfully restricted and inappropriate decisions could be made on a person's behalf if they lacked capacity to make the decision for themselves.

Risk assessment and management was poor. Medicines were not always administered safely and in line with best practice and any prescriber instructions. The premises were not kept safe.

Standards of cleanliness were poor and infection prevention and control was not always well-managed.

The service did not have robust and effective processes in place to protect people from abuse or investigate and act on allegations or evidence of abuse.

The service did not ensure staff were sufficiently trained, supervised and appraised in their roles. It also failed to ensure that staff of good character and with suitable competence, skills and experience were employed.

The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided. People's personal information, such as care records, was not stored securely. Contemporaneous records of people's care were not kept up-to-date. The service failed to notify CQC of incidents which occurred at the service, as required.

You can see more information in the Detailed Findings below.

Rating at last inspection:
This was our first inspection of the service since the provider acquired it in December 2017.

Why we inspected:
This was a planned comprehensive inspection.

Follow up:
Following the inspection we arranged to meet with the provider and the local authority to discuss the concerns we identified and seek reassurance as to how the provider would deliver the required improvements.

The overall rating for this registered 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; and
• 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 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.

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Cressington Court Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The first day of the inspection was carried out by one adult social care inspector, a specialist nursing adviser and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was carried out by two adult social care inspectors.

Service and service type:
Cressington Court Care Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The first day of this inspection was unannounced and the second was announced.

What we did:
Before the inspection we checked the information that we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A

notification is information about important events which the service is required to send us by law. The provider had completed a Provider Information Return (PIR). 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 also obtained feedback from the local authority and the clinical commissioning group.

During the inspection we looked around the premises, observed the interactions between people living at the home, care delivery and activities provided at the home. As some people were unable to give us their views 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.

We spoke with six people living at the home, five people's relatives and several staff who held various roles at the home, including the registered provider, regional director, registered manager, deputy manager, nurses, carers, activities coordinator and kitchen staff. We looked at a range of documentation including five people's care records, medication storage and records, three staff files, accident and incident records, safeguarding records, health and safety records, complaints records, audits and records relating to the quality checks undertaken by staff and other management records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse
• The service did not have robust and effective processes in place to protect people from abuse or investigate and act on allegations or evidence of abuse. This meant that people were not effectively safeguarded from abuse.
• On reviewing the service's incidents file we found that a person living at the service had reported a safeguarding concern to staff at the start of February 2019. The incident form shows this was 'reported to senior'. However, at the time of our inspection, a few weeks after this was initially reported, no further action had been taken. The registered manager was not aware of these concerns, they had not been reported to the local authority, investigated or reported to CQC. This demonstrates that staff at the service failed to understand and act upon their responsibilities relating to safeguarding vulnerable people.
• Staff training records were also disorganised and unclear. However, the records available showed just three members of staff had received safeguarding training in the past 12 months.

These concerns represent a breach of the regulations in relation to safeguarding people from abuse.

Assessing risk, safety monitoring and management
• Risk assessment and management at the service was poor and placed people at unnecessary and avoidable risk of harm.
• The service has just started refurbishment works at the home. At the time of our inspection the contractors were working on a corridor area where there were seven people still living in the bedrooms. The risk assessment for these works did not contain any information about how staff would support people to safely access their rooms and manage the risks associated with this. We also found that the rooms the contractors were using to store their tools and materials were not locked and people living at the home could have accessed these potentially dangerous items.
• We found one person's choking risk assessment indicated they needed a swallowing assessment. A referral was made but rejected as the person was under the care of another service but this had not been acted upon and no assessment was planned.
• We found that the risks associated with one person's pressure area care were not managed appropriately. Their care plan did not contain guidance about the correct mattress setting, staff did not know what the correct setting was and when we checked the mattress it was set at an incorrect weight setting for the person.

• The premises were not kept safe for people living at the service which also placed people at unnecessary and avoidable risk of harm.
• Three gas boiler rooms were cluttered with combustible materials, including excess furniture and care records for archiving. There was also a spare room excessively cluttered with disused equipment etc. These

rooms were cleared by the end of our inspection.
• The cleaning store cupboard had been left unlocked so there was unrestricted access to various cleaning chemicals. We also found a spray bottle of hard surface cleaner had been left in a communal toilet.
• The application of window restrictors at the service was haphazard and unsafe. The upper sections of some first floor corridor windows did not have restrictors. Other ground floor windows did not have restrictors, including the staff room which did not have a door lock. During our inspection window restrictors were installed to the highest risk windows and additional restrictors had been ordered for across the service.
• The security of the building was not maintained. A large section of the perimeter wall was missing, as were several fence panels to either side of the premises. The ground floor staff room window did not have a window restrictor and was left open and the door to this room did not have a lock. A door at the rear of the property was also left open. This meant that ingress to and egress from the home could not be securely monitored.
• Several storage cupboards along a corridor on the first floor had been left unlocked. One contained a person's belongings, including alcohol, jars of screws, nuts and bolts. Another cupboard contained nail varnish and nail varnish remover. Similarly, in the unlocked ground floor staff room we found a box of hearing aid batteries. We also found a pair of scissors and some fish food in an unlocked cupboard under a fish tank in the communal lounge on the ground floor. All of these items were potentially harmful to the people living at the service.
• A makeshift food preparation room had been set up on the first floor with no regard to food hygiene standards or best practice. There was a microwave, kettle bain-marie and fridge in the room. There were some cereals, tea and coffee and squash. None of the food and drink in the fridge was labelled. This included a stainless-steel jug of milk which was no longer entirely liquid. There was also two open cartons of almond milk in the fridge with no label to say when they were opened. These should be consumed within five days of opening. The room was dirty, as was the single sink, the bin, fridge, bain-marie and cutlery tray. The registered manager assured us that this room would no longer be used for this purpose.
• The corner of one person's bedroom showed signs of water damage to the ceiling and walls. The light at head height above their bed also did not have any kind of fitting or shade, just a bare bulb.
• One communal bathroom on the first floor had an overpowering smell of damp. The wood around the toilet boxing in the pipework was brown and warped. The registered provider and registered manager explained that the bathrooms at the service were included in the planned refurbishment works.

Preventing and controlling infection
• Standards of cleanliness were poor and infection prevention and control was not always well managed.
• The general cleanliness of the home was poor, floors were dirty with dust and ingrained dirt.
• The covers on some items of furniture on both floors were cracked and/or ripped making them impossible to keep clean. Some foam chair cushions in the conservatory had had the covers removed but were still in place for people to sit on. The bare foam cushions were removed by the registered manager.
• There was a non-slip mat in the ground floor wet room. We saw that the underside of the mat was covered in black mould. The registered manager disposed of this item.
• A communal toilet on the first floor was very dirty. The underside of the seat was stained with faeces and/or urine. The walls were stained with liquid marks. There was also a mop and bucket being stored in this toilet, in which the water was a dark grey colour.

These concerns represent a breach of the regulations in relation to safe care and treatment.

Staffing and recruitment
• The service failed to ensure that staff of good character and with suitable competence, skills and experience were employed. This meant people were at risk of receiving care from staff who were unsuitable or unsafe to do so.

• None of the staff files we looked at had a recent photograph to assist identification, as is required.
• One staff file contained just one reference, which was a generic, unverifiable character reference not from the person's most recent employer.
• We noted that the registered manager had carried out audits of some staff files in January and February 2019. These confirmed that the files we reviewed were examples of wider systemic failings in staff recruitment processes at the service, as the audits concluded overall compliance scores of 35% and 42%.

These concerns represent a breach of the regulations in relation to fit and proper persons employed.

• People and their relatives gave us mixed feedback about whether there were enough staff at the service. One person said, "They are short of staff, always running around. Sometimes I wait a long time when I use my call bell, it depends how many staff are about." Relatives commented, "When I visit there are plenty of staff about and always a member of staff in the lounge" and "The staffing levels are better than they were, they are acceptable."
• We looked at staff rotas and observed staffing levels during our inspection. We saw that there were enough staff to meet people's basic needs.
• The registered manager told us the service was using agency staff for approximately nine shifts per week. However, they tried to use the same agency staff for continuity as far as possible.

Using medicines safely
• Medicines were not always administered safely and in line with best practice and any prescriber instructions. This placed people at unnecessary and avoidable risk of harm.
• Covert medicines were not being given in accordance with the Mental Capacity Act 2005. For example, for one person living at the home staff did not have clear guidance on what medicines were to be administered covertly nor did they have advice from a pharmacist about how the covert medicines could be given safely.
• A bottle of liquid antibiotic had not been marked with the date it was opened. This was not in line with best practice and meant there was a risk staff would not be able to accurately monitor the expiry date of the medicine.
• Records showed that people did not always receive support with their topical creams as prescribed. We saw three people's which were blank and showed no creams had been applied in February 2019.

These concerns represent a breach of the regulations in relation to safe care and treatment.

Learning lessons when things go wrong
• Accidents and incidents were documented. However, as demonstrated by the lack of action taken on the safeguarding concern referred to above, this information was not always appropriately acted upon. The fact that the registered manager was unaware of this also indicated a lack of oversight in this area.
• The service did not have a system in place to robustly analyse this information and learn lessons from any accidents and incidents that had occurred.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Ensuring consent to care and treatment in line with law and guidance
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.

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. 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 and whether any conditions on authorisations to deprive a person of their liberty were being met and found that they were not. This meant that people were at risk of having their liberty unlawfully restricted and inappropriate decisions could be made on a person's behalf if they lacked capacity to make the decision for themselves.
• We found that mental capacity assessment and best interest decision documentation was not always completed and left blank.
• We found that one person who had been assessed as lacking capacity had signed a consent to care and treatment form.
• One person was receiving their medication covertly. However, there was no mental capacity assessment or best interest decision to support this, as is required.
• DoLS applications and authorisations were not effectively managed by staff at the service. For example, we found one person's DoLS authorisation had expired around a month before our inspection. There was no evidence that this had been identified or reapplied for until we highlighted this during our inspection.

These concerns represent a breach of the regulations in relation to consent.

Staff support: induction, training, skills and experience
• The service did not ensure staff were sufficiently trained, supervised and appraised in their roles. This meant that people were at risk of being supported by staff who did not have the necessary skills and competence to do so safely.
• Staff training records were disorganised and unclear. Neither the registered manager nor the regional director were able to confidently confirm what training had or had not been delivered for staff at the service in the last 12 months or how this had been managed by the previous registered manager.

• The supervision and appraisal records were also reflective of the above. In some cases, records indicated that staff had had just one supervision in a 12-month period. An audit in January 2019 also noted that '0%' of staff had received appraisals.
• We discussed this with the registered manager who explained they were aware of this problem and they had started conducting staff supervisions and appraisals, along with reviewing staff training.
• The registered manager also told us that since they started working at the service in November 2018 they had implemented a formal induction process, mapped against the Care Certificate. However, prior to this they told us that new staff were not supported with any induction relating to care delivery.

These concerns represent a breach of the regulations in relation to staffing.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments of people's care needs had not always been completed in detail. Some care plans lacked detail around specific needs and did not always reflect information in other records. This meant people were at risk of not having their needs safely and effectively met.
• For example, one person's pressure area care needs were not managed appropriately. We found their care plan did not contain guidance about the correct mattress setting, staff did not know what the correct setting was and when we checked the mattress it was set at an incorrect weight setting for the person.
• Assessments were obtained from other health and social care professionals and used to help plan effective care for people. However, this information was not always obtained in a timely manner.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us the food at the service was acceptable but there were limited choices of what to eat and drink. People commented, "When I first came the food was cold and unappetising, its improved now and my food is hot. There seems to be a choice now if I say I don't like what's on offer", "Its adequate. We don't really get a choice but if I don't like what's on offer, I would ask for something else." and "The food is just ok."
• Records showed that when people required their intake to be monitored, this was not always recorded. This meant that there was a risk people were not receiving the amounts of food and drink that they required to meet their needs.
• For example, one person's food and fluid charts were not completed for breakfast on the first day of our inspection. No fluids were documented after 6:30pm the day before and similarly there were no records after 6:00pm the day before that. The records that had been completed did not record the amounts the person ate or drank. This person had also been prescribed supplement drinks. Staff told us that the person had three of these drinks each day. However, there were no records to support this.

Supporting people to live healthier lives, access healthcare services and support
• Where people required support from healthcare professionals this was arranged and staff followed guidance provided by such professionals. Information was shared with other agencies if people needed to access other services such as hospitals.
• Staff did not always identify changes in people's needs and make referrals to appropriate healthcare professionals in a timely manner. For example, staff had failed to follow up on and arrange a swallowing assessment for someone at risk of choking after the referral had initially been rejected by another service.

Adapting service, design, decoration to meet people's needs
• Technology and equipment was in place effectively to meet people's care and support needs. People had access to call bells to alert staff to when they required support. Those who were unable to use a call bell had a sensor mats in their in room to alert staff.
• Some of the people living at the home were living with dementia. We saw there were some basic adaptations at the home to assist people living with dementia, such as large, easy-read signage.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported
• People and their relatives gave us mixed feedback about the staff at the service. Comments included, "I can't fault the staff, they make this Home. They are encouraging all the time" and "The majority of the staff are ok, a few I am not keen on, they treat me like a dementia patient, I object to be spoken down to. The staff are mainly kind and patient, younger ones and agency staff are different."
• We observed some caring interactions between staff and the people living at the service. One member of staff in particular was warm, friendly and familiar with the people they were supporting. However, aside from these, we saw some very poor interactions which lacked compassion and showed an uncaring attitude from staff.
• One person in the dining room was repeatedly calling out 'where am I' 'where are you' and was clearly anxious. During the 30-minute period we observed, several staff in the room ignored this person's distress and no interaction or reassurance was given. There was just one interaction to give them a drink, when the carer simply said 'here you go'.
• We observed two carers providing 1:1 care at lunchtime. For a period of 10 minutes the carers talked to each other and ignored the people they were supporting. This included whilst supporting someone with their meal.

Respecting and promoting people's privacy, dignity and independence
• People were not always treated with care and compassion and were sometimes left in undignified situations. This meant that the service failed to treat people with dignity and respect.
• People's personal information, such as care records, was not stored securely. This meant people's privacy was not always maintained.
• We found the office on the residential floor which stored people's care plans and other records was left open. We saw people's care files were left unattended in a box on the floor in the ground floor lounge. We found three boxes of care records that required archiving in the unlocked staff room.
• On the first day of our inspection we found one person sat in the communal lounge at around 9:30am wearing just a vest and underwear with bare feet.
• Later that day we observed staff hoisting a person into a chair. The person was wearing a skirt and the position of the hoist strap meant that the person's skirt moved and exposed her underwear. Staff did not communicate with the person whilst they were hoisting them to offer any reassurance, nor did they attempt to preserve their dignity by placing a blanket over their legs.

These concerns represent a breach of the regulations in relation to dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
• People, as far as possible and along with family members, were encouraged to share their views about the care people received during care plan reviews and meetings.
• However, as we have explained earlier in this report, we found concerns relating to consent and decision-making when people lacked capacity. For example, one person who had been assessed as lacking capacity who had signed a consent to care and treatment form.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•Some people's care plans contained contradictory information, had not been updated and lacked detail. For, example one person's care plan stated that they were compliant taking their medication. However, information elsewhere indicated they were to be given their medicines covertly.
• People were not always receiving support as documented within their care plans. For example, one person's care plan stated they were to be repositioned every hour and a half. However other records indicated staff were not following relevant guidance.
• Some of the care plans we reviewed contained some personalised information. There was clear information on how to support people with any communication needs. For example, ensuring people who wore hearing aids or glasses were supported to wear them. This meant the service was acting in line with the Accessible Information Standard.
• People had access to a range of activities. The service had recently employed a full-time activities coordinator, who worked flexibly throughout the week; they showed an enthusiastic and positive approach and had some creative ideas for activities for people to get involved in.
• The activities co-ordinator had recently arranged for some Shetland ponies to visit the service, which people enjoyed seeing and petting. They had also ordered some chickens to live in the outdoor space.
• People's cultural and spiritual needs were also considered, as a multi-faith minister had been organised to attend the service once a month to perform a service for people that wanted it.

End of life care and support
• At the time of our inspection none of the people living at the home were actively receiving end of life care. However, we saw that anticipatory medicines had been stocked for people where necessary.
• People were supported to make decisions about their preferences for end of life care, and were involved in developing care and treatment plans. Care plans included people's advanced decisions about their end of life wishes.

Improving care quality in response to complaints or concerns
• The home had a complaints policy and procedure in place. People and their relatives were encouraged to make a complaint if they needed to and the details of how to do so were easily accessible. However, we found that some of the contact details displayed by the front door of the service required updating.
• People and their relatives told us they felt comfortable raising any concerns if necessary.
• We reviewed the home's complaints records and found that complaints were appropriately recorded and responded to in a timely manner.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care
• Senior staff were out of touch with the scale and seriousness of the failings we identified at the service.
• The serious and varied nature of the breaches of the Regulations we have identified demonstrate a failure of leadership and governance.
• The negative interactions we observed between staff and people living at the service, along with the undignified situations we saw, demonstrated the culture at the service lacked care and compassion.
• Maintaining standards of high-quality care and support were not always valued at the service. Records relating to people's care were not always kept up-to-date. For example, at around 3:00pm on the first day of our inspection we found at least five people's observations, food and fluid charts and repositioning charts had not been completed for that day.

• The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided. This placed people at unnecessary and avoidable risk of harm.
• The numerous and varying breaches of the Regulations we have identified demonstrate that quality assurance processes at the service are inadequate and have failed. For example, a 'house audit' carried out in January 2019 failed to identify the issues we did on inspection.
• We noted that the registered manager, who had been in post for a few months, had started to implement some audits and quality assurance was an area they identified as needing improvement. However, at the time of our inspection, these were yet to deliver any improvements.

These concerns represent a breach of the regulations in relation to good governance.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The service failed to notify CQC of incidents which occurred at the service, as required. We found four examples of safeguarding incidents which the service had not notified us about in the past three months. This indicated that the service did not have the necessary oversight in this area and it hindered our regulatory monitoring of the service.

These concerns represent a breach of the regulations in relation to notification of other incidents.

• People's personal information, such as care records, was not stored securely. This meant people's privacy was not always maintained.

Working in partnership with others

• The service did not have any links with local organisations or external bodies to obtain information about best practice or gather ideas about how to develop and improve the service.

• At the time of our inspection senior staff acknowledged that significant improvements were required at the service and they assured us that they were committed to positively engaging with the relevant organisations to do so.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The service had some systems in place to gather feedback about the service. These included regular residents' and relatives' meetings and questionnaires.

• The registered manager held regular staff meetings, which provided staff with the opportunity to receive and share any important information.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify CQC of incidents which occurred at the service, as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with care and compassion and were sometimes left in undignified situations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in line with the MCA 2005 and the associated DoLS.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessment and management was poor. Medicines were not always administered safely and in line with best practice and any prescriber instructions. The premises were not kept safe. Standards of cleanliness were poor and infection prevention and control was not

always well-managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not have robust and effective processes in place to protect people from abuse or investigate and act on allegations or evidence of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided. The serious and varied nature of the breaches of the Regulations we have identified demonstrate a failure of leadership and governance at the service. People's personal information was not stored securely. Contemporaneous records of people's care were not kept up-to-date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service failed to ensure that staff of good character and with suitable competence, skills and experience were employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not ensure staff were

Treatment of disease, disorder or injury	sufficiently trained, supervised and appraised in their roles.