McLaren House Limited

McLaren House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
McLaren House is a care home which is registered to provide personal care for up to 9 people with mental health needs. There were 7 people being supported at the time of our inspection.

People's experience of using this service and what we found

Although people told us they felt safe, the systems in place failed to ensure people would always be protected and safe from risk of harm and abuse. Numerous incidents including abuse and/or allegations of abuse had been overlooked. These concerns were not escalated to relevant partner agencies as required, such as the local authority and notified to CQC. This amounted to two breaches of regulations due to the provider's failure to protect people from harm and abuse, and to always notify the Commission as required of specific incidents and events including safeguarding matters. The provider and staff failed to respond appropriately to safeguarding concerns and people remained at ongoing risk of harm and abuse as a result.

We identified a third breach of the regulations due to the poor management of people's risks, medicines, and further significant shortfalls in the safety of the service. Incidents including where people had come to harm, were not learned from to prevent reoccurrences and to safely manage risks. Our inspection found people's risks were not adequately assessed and known to all staff, and poor management and oversight of the premises and medicines management presented further risks to people's safety.

We identified a fourth breach of the regulations because staff were poorly deployed. Systems were not in place to establish how many staff were needed to safely meet people's needs at all times and to ensure staffing levels were always safe. This included the provider's absence from the service although they were on the rota to attend on the day of our inspection. Recruitment processes were not robust. We found infection control concerns and improvements were required to health and safety checks.

Although people spoke positively about their support, our review of records found people's needs were not adequately assessed or detailed to inform effective support at all times. Information and/or learning about incidents were not shared with staff. Staff did not have sufficient training and guidance for their roles and the service was not fully adapted and maintained to promote people's safety as far as possible.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support consistently good practice.

People were supported by staff to access further healthcare support when needed. Most people spoke positively about the home's food and some people prepared their own meals. Staff told us they felt supported.

We saw positive interactions from staff and most people spoke positively about staff. However, the inadequate response to safeguarding matters and incidents at the service, by staff and the provider, failed to ensure people were always well treated and supported. People were not supported to always have their views heard and acted on; and to be involved in their care as far as possible. We saw and heard examples of how people's privacy and independence was promoted.

Care planning processes failed to capture people's individual needs and preferences and ensure these could be met as far as possible, including people's communication needs. Most people spoke positively about the service and told us they would recommend it. People had access to doing things they enjoyed but told us there were not enough activities led by the home. Most people told us they would feel comfortable complaining if they needed to, although we saw other concerns and issues were not always adequately responded to.

We identified a fifth breach of the regulations because the provider did not have systems and processes in place to adequately support people and staff. We found widespread and significant shortfalls in the quality and safety of the service which exposed people to ongoing risk of harm and poor care, including around medicines management, learning from incidents, risk management, the safety of the premises and ensuring staff were sufficiently skilled and suitably deployed. Despite our urgent prompts, the provider failed to act on the serious concerns we brought to their attention.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published July 2017).

Why we inspected
The inspection was prompted in part due to concerns about the provider's governance systems and oversight of the quality and safety of care provided, identified through our inspection activity at another service registered with the provider. We decided to inspect and examine those risks.

We identified serious concerns and breaches of the regulations at this inspection. We found evidence that people were at risk of harm as a result. Despite our urgent prompts and enforcement activity, the provider did not take enough action to mitigate those risks. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We identified five breaches of the regulations at this inspection. This was because the provider failed to protect people from abuse and ensure any allegations of abuse were immediately investigated. The provider failed to adequately assess and mitigate risks to people's health and safety, including risks posed by their poor upkeep of the premises and poor management of medicines. We identified further safety shortfalls that the provider failed to ensure there were sufficient numbers of suitably skilled and competent persons deployed to safely meet people's needs. The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This included the further breach of the provider's failure to notify CQC of all incidents that affect the health, safety and welfare of people using the service.

After our inspection, we took urgent enforcement action to require the provider to immediately address significant concerns that placed people at immediate risk of harm. We informed relevant partner agencies of our serious concerns. The provider failed to take enough action to ensure people's safety which continued to place people at immediate risk of harm. We continued to liaise closely with the local authorities and other

relevant partners. We carried out a responsive inspection of the third service registered with the provider based on the concerns we had identified.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
During and after our inspection processes, we requested information from the provider about what action they were taking to address our serious concerns. We also worked alongside the relevant local authorities in light of the concerns we identified. We carried out urgent enforcement action in relation to this service. During our enforcement processes, we continued to monitor the service for any further concerning information to help inform our inspection activity.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

McLaren House

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
McLaren House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The nominated individual is responsible for supervising the management of the service on behalf of the provider. The nominated individual was also the registered provider and registered manager for this service. Registered persons are legally responsible for how the service is run and for the quality and safety of the care provided. We refer to the nominated individual and registered manager as the 'registered provider' or 'provider' within this report. The provider did not attend the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We liaised with the local authority and professionals who work with the service. We checked for any feedback available through Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who lived at the home and observed the care and support people received. We spoke with six staff members including five senior support workers, one care assistant and a new starter who advised they were the deputy manager. We held discussions with local authorities and health professionals involved in people's care throughout our inspection and enforcement processes.
We reviewed a range of records. This included records related to each person living at the home and three people's medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
During and after our inspection, we continued to share information and the concerns we had identified with the provider and the local authorities and professionals involved in people's care. We continued to seek updates and assurances from the provider. We made formal requests for some information related to the quality and safety of the service including a person's care plan which was not available during the inspection. We also requested three staff recruitment files yet the provider was only able to provide evidence of recruitment checks for two of those staff members.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People we spoke with told us they felt safe and secure at the home. However, numerous incidents including abuse and/or allegations of abuse had not been adequately responded to and escalated to relevant partner agencies such as the local authority.
- This included allegations of sexual abuse and verbal abuse made against staff. The provider failed to take adequate action to protect service users from harm despite our prompts. We took urgent enforcement action and raised our concerns with the local authority.
- Additional risks and safeguarding concerns such as altercations between people living at the home were also not reviewed and appropriately escalated to help prevent future reoccurrences.
- Our discussions with the provider and staff found they made their own judgements as to the validity of allegations of abuse. They failed to understand their responsibilities to protect people from abuse. Staff had either not received safeguarding training from the provider, or it had expired.

The provider's systems failed to protect people from abuse and ensure any allegations of abuse were immediately investigated. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- There were several hazardous items on the premises, including ligature points, discarded bricks and furniture. These risks had not been assessed, reduced and/or removed wherever possible. This disregarded the service provision of supporting people with mental health needs and failed to consistently manage some people's known risks associated with suicide and self-harm.
- People's risks associated with people's mental health, were not clearly and adequately assessed to help inform safe care and promote people's safety as far as possible.
- New or increased risks identifiable through incidents were not assessed and monitored, including concerns about one person's sexual behaviour which could place others at risk of harm.
- One person showed signs of potential relapse which placed people and staff at harm, however there was no clear guidance about how to effectively monitor and manage this person's risk.
- This person had recently physically attacked staff twice. There was still no oversight to learn from these incidents; to prevent reoccurrences, and ensure the person and staff were all appropriately supported and aware of how to respond to such incidents and emergencies in future.

Using medicines safely

- One person was prescribed PRN ('as and when needed') medication to help them become calm. Necessary processes to help ensure this medication was used appropriately were not in place.

● Staff confirmed, and records showed the person was being given this medication every day, with no recorded reasons for this excessive use. Staff did not offer a rationale or any clinical basis for this decision. We alerted the local authority of this potential misuse of this person's medicines.
● Staff responsible for medicines support, had not had competency assessments and did not all have current medication training. This failed to ensure staff knew how to support people safely.
● Medicines records did not provide sufficient guidance, for example to ensure safe use of people's PRN medicines and topical creams.

The provider failed to adequately assess and mitigate risks to people's health and safety, including risks posed by their poor upkeep of the premises and poor management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People gave positive feedback about their medicines support. One person told us, "I have done so well because staff had supported me with my medications." Another person told us, "I have them on time, I'm happy with that support."
● Some necessary health and safety checks were carried out but this was not consistent. People were involved in practice fire drills.

Staffing and recruitment
● Staff had inconsistent awareness of some people's risks associated with their physical and mental health, and were not informed or trained on how to respond appropriately in the event of an emergency such as recent incidents where one person had physically attacked staff.
● The provider and staff gave mixed feedback about the level of support and monitoring some people needed to ensure their safety. Records did not clarify what the staffing arrangements should have been. One staff member told us, "We don't allocate staff we work together."
● Staffing levels and deployment were not appropriately managed. Although the provider was on the rota to work on the day of our inspection, they did not arrive and had not adjusted the rota when they were not available.
● We met one staff member who told us they were the new deputy manager and other staff confirmed this. We saw the deputy manager spent time unsupervised with people living at the home, although they could not tell us people's risks or support needs. After our inspection, we found out the deputy manager had not completed any recruitment checks.
● After our inspection, the provider also told us this person had been mistaken as the deputy manager and denied that the deputy manager had not been left unsupervised.

The provider failed to ensure there were sufficient numbers of suitably skilled and competent persons deployed to safely meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All staff told us they felt there were enough staff, for example because some people often went out during the day.
● After our inspection, the provider submitted evidence showing recruitment checks had been carried out for two staff members we chose at random. The provider told us they had identified improvements were needed to their recruitment processes to ensure staff were always suitably recruited. The provider was not able to evidence robust recruitment processes were in place.

Preventing and controlling infection
● Potatoes for people to eat were stored on the kitchen floor, and we saw a mousetrap was on the floor in

the next room.

● We saw staff failed to use the personal protective equipment available on site, when preparing food and handling soiled clothing and linen.

● People's survey responses showed they felt the home was safe, clean and tidy.

Requires Improvement

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.

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- Care records did not provide clear guidance and sufficient detail about people's choices, wishes, risks, histories and mental health. This was although some people had lived at the home for many years. This demonstrated people's needs and choices were not adequately assessed.
- People's physical health needs and conditions were not adequately assessed to ensure staff knew how to support people and to provide care in line with current good practice.
- Staff helped people access further mental health support when they were unwell. However, people's needs were not assessed effectively to ensure all staff knew how to meet people's needs in the interim and whilst home.
- Most people spoke positively about staff. One person told us, "Staff have always been good here… The staff don't leave anything to chance and they are very proactive looking out for triggers to mental health." The person felt staff understood their needs and condition.

Staff support: induction, training, skills and experience

- The majority of staff training was outdated or had not been provided including in core areas such as safeguarding, fire awareness alongside staff training gaps in First Aid, Medication and Health and Safety.
- Records showed most staff had either never received the provider's First Aid and 'Dealing with Challenging Behaviour & Aggression' training or this had expired. This combined with poor risk assessments and records failed to ensure staff had the skills and competence to support people effectively. After our inspection, the provider told us they were reviewing their training plans.
- Staff did not all know about people's risks and incidents at the home. This meant staff could not have a full understanding of people's needs and how to provide effective support.
- Staff told us they completed an induction and shadowing before they started in their role. Staff said they could contact the manager when needed.

Adapting service, design, decoration to meet people's needs

- There were several hazards in the home and garden area, which and had not been assessed, reduced and/or removed as far as possible. This failed to show regard for the nature of the service and people's known needs associated with their mental health.
- People had been involved in discussions about some of the home's décor.
- Some areas of the home were maintained and decorated in a homely way.

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 that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Most staff were unaware of the requirements of the MCA although training was provided.
● Everyone living at the home were subject to safety checks throughout the night, however people were not consulted on this or given a choice about this routine practice. One person told us these checks did not disturb their sleep.
● Although staff said some people's capacity fluctuated due to mental health, there was no guidance about how people could be supported to make their own decisions as far as possible.

Supporting people to live healthier lives, access healthcare services and support
● People told us they discussed how they were feeling with community professionals.
● One person told us they would be supported to access healthcare services if needed. Staff had contacted people's healthcare teams when they had identified concerns and kept records of people's attendance to healthcare appointments. This helped people to get the healthcare support they needed.

Supporting people to eat and drink enough to maintain a balanced diet
● Most people spoke positively about the home's food and told us they were offered choices. People were offered alternative options such as vegetarian foods.
● One person told us they had plenty to eat and drink. Another person told us, "It's quite nice." People were supported to prepare their own meals.

Requires Improvement

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Incidents where people had been subject to harm through altercations and alleged abuse; had not been adequately responded to and prevented where possible in future. These significant safety shortfalls failed to ensure people could always be appropriately and fairly supported.
- Where people had made allegations of abuse, they were not always listened to and appropriately supported. Records showed when one person alleged they had been sexually assaulted; the person was instructed to sit in another room and to calm themselves down.
- One person told us "Staff just take no notice." The person told us they did not feel treated with respect and felt they didn't get on with staff. We saw staff did not always use opportunities to engage with this person when they were nearby.
- We saw some positive interactions between people and staff. One staff member told us, "We see everybody here as our family, we look forward to seeing them." A relative told us, "The staff listen to [person], they give me support when days are darker."

Supporting people to express their views and be involved in making decisions about their care

- Improvements were needed. People did not have regular opportunities, for example, care reviews, to discuss their individual care needs and decisions about their care.
- People had been asked to complete feedback surveys. Responses were often positive but we saw people gave mixed feedback in areas such as whether staff were friendly and polite and if they could speak to staff about anything. This feedback had not been explored or acted on.
- People's views about the home were gathered during residents' meetings, for example people were asked if they were happy with the service and new residents were welcomed and asked how they were getting on.

Respecting and promoting people's privacy, dignity and independence

- Staff told us they promoted people's privacy by respecting confidentiality and ensuring people were supported with discretion.
- One person told us, "Staff have helped with hygiene and improving my independence. The staff have supported me to get into gardening which brought me out of my shell and the staff support me to volunteer as a gardener."
- People were supported to carry out daily living tasks such as cooking and shopping. Some people went out as they pleased and were encouraged to be part of the community.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans contained current information such as upcoming health appointments, but did not provide key information about people's current and/or previous needs and preferences, although some people had lived at the home for many years.
- People also did not have opportunities such as regular care reviews, to discuss their needs and preferences, to help inform and plan personalised care.
- Some people spoke positively about their experiences and progress at the home and told us they would recommend the service to others. One person told us, "I'm happy… I've been here a year or so and I love it." A relative told us, "I'm happy with the [service], the staff help us."
- One person who wanted to leave was being supported to do so by their professionals. This showed the person was being supported to have control over their care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Improvements were needed to ensure this standard was fully met for some people with identified communication needs.
- For example, a staff member told us, "[Person] needs a lot more support in how you explain things to [them]. Need to communicate everything step by step to [person]." Staff described having become familiar with how to communicate with this person, although the person's care plan provided limited guidance and did not state if any communication tools could be of help.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff often knew how people liked to spend their time and people's interests, although care plans lacked this guidance about people's individual choices and preferences.
- People told us there were not enough activities or things to do at the home. One person told us, "There isn't much to do here." Another person told us, "The same again when I come [downstairs], bored and not doing anything." Both people followed their own interests otherwise.
- Staff told us they tried to encourage people to spend time with one another, for example to play board games. Some people went on holiday together during the last summer.
- Some people regularly went out, for example to a day centre, and were involved in activities and

community links they valued. One person attended religious services with their relative.

Improving care quality in response to complaints or concerns

● Some people had raised concerns including safeguarding matters. Although these concerns had been recorded, systems failed to ensure concerns would always be addressed and used to improve the quality of the service and people's experiences.

● People had been informed about how to complain about the service if they needed to. Records indicated no formal complaints had been made.

● Most people told us they would feel comfortable making a complaint. Advocacy support had been arranged for one person who was not happy at the home and had concerns about staff. One person told us they would feel comfortable complaining if they needed to. Another person told us, "I do feel I can raise the concerns, I have never had to."

End of life care and support

● People did not require this level of support. The provider told us they would liaise with other health professionals if this support was needed.

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.

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's ineffective systems meant allegations of abuse were overlooked. This put people in their care at continued risk of harm and abuse. The provider failed to address this to prevent the safety of the service being further compromised, despite our urgent prompts.
- Staff used a 'Work Book' to inappropriately document some safeguarding matters and occasions where people had come to harm. There were no systems to identify and cease this concerning practice. These additional safeguarding concerns were also not escalated to protect people from abuse.
- Staff said they felt supported and able to raise any concerns with the provider. One staff member told us, "We've worked with [people] for so long, you see." However the provider failed to protect people and staff with adequate staff training and guidance, and to develop processes to ensure shortfalls in the safety of the service were learned from and prevented in future.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not act on the duty of candour to respond appropriately to incidents and safeguarding matters and to protect people in their care from harm. This meant people and staff remained exposed to risk of harm.
- Recent incidents meant staff had come to risk of harm, including one staff member being pinned against a wall by a person living at the home. There had been no reviews or debriefs following this incident to help effectively assess, monitor and manage risks moving forward.
- Staff were not all aware of safety incidents and risks which did not promote openness and learning.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We met a new deputy manager who told us they had joined a week ago. Staff confirmed there had not been a deputy manager in post for two years. After our inspection, the provider told us this was inaccurate and the staff member had not been recruited as a deputy manager. This shows staff were unclear about their roles.
- Poor governance systems meant shortfalls in care planning and medicines management were not identified and improved. People's care records were not complete and accurately maintained. Systems did not address excess medicines stock and poor medicines record keeping.
- Systems failed to ensure the safety of the premises, for example, to reduce hazards wherever possible, to

ensure good infection control and to carry out sufficient health and safety checks.
● The provider had failed to notify relevant partner agencies of specific incidents and events including safeguarding matters.

Failure to notify CQC of all incidents that affect the health, safety and welfare of people using the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
● We are deciding our regulatory response to this and will publish our actions if made.
● The provider displayed their previous inspection ratings as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Some people completed feedback questionnaires about the home. Although the feedback had been analysed and found potential areas of improvement, the provider could not demonstrate they had acted on this feedback to improve people's experiences and the quality of the service.
● Staff told us nobody had made specific requests around their equality characteristics however care planning did not ensure these needs were routinely identified, assessed and met. People were not involved in regular discussions about their care.
● The provider failed to adequately address and respond to our concerns during inspection and enforcement processes. This was despite the seriousness of the concerns which placed people at immediate and ongoing risk of harm and poor care.

Working in partnership with others
● Before our inspection, the local authority visited this service. We saw concerns identified by the local authority were still of concern at the time of our inspection and had not been adequately addressed by the provider. The local authority continued to engage with the provider during and after our inspection and enforcement processes.

The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We continued to liaise with the local authority about our significant concerns.
● One staff member told us they felt able to raise concerns with management and would recommend the service. They told us, "Because of how [the provider] is as a person and cares for people and staff."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess and mitigate risks to people's health and safety, including risks posed by their poor upkeep of the premises and poor management of medicines.

The enforcement action we took:

Urgent imposing conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess and mitigate risks to people's health and safety, including risks posed by their poor upkeep of the premises and poor management of medicines.

The enforcement action we took:

Vary a condition

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's systems failed to protect people from abuse and ensure any allegations of abuse were immediately investigated.

The enforcement action we took:

Urgent imposing conditions

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's systems failed to protect people from abuse and ensure any allegations of abuse

were immediately investigated.

The enforcement action we took:

Vary a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Urgent imposing conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Vary a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably skilled and competent persons deployed to safely meet people's needs.

The enforcement action we took:

Urgent imposing conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably skilled and competent persons deployed to safely meet people's needs.

The enforcement action we took:

Vary a condition