McLaren House Limited

St Andrews Court

Inspection report

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25 September 2019
02 October 2019
03 October 2019
16 October 2019

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

Summary of findings

Overall summary

About the service
St Andrews Court is a care home which is registered to provide personal and nursing care for up to 12 people with mental health needs. St Andrews Court accommodates 12 people in one adapted building and there were 12 people being supported at the time of our inspection.

People's experience of using this service and what we found
Numerous incidents including abuse and/or allegations of abuse were not adequately responded to and escalated to relevant partner agencies such as the local authority. This meant people were not protected from harm. People did not all feel safe. Incidents including where people and staff had come to harm, were not learned from and risks were not adequately managed. This was a breach of the regulations.

We identified a second breach of the regulations due to inadequate risk management and further significant shortfalls in the safety of the service. People's risks and complex needs were not adequately assessed and known to all staff, and the premises presented hazards and further risks to people's safety. Where people's risks were known to staff, they were not consistently managed. Systems also failed to ensure safe medicines management at all times.

We identified a third breach of the regulations because there were not enough suitably skilled and qualified staff, including nurses, to safely meet all people's needs. This meant clinical support, agreed with local authorities, could not always be provided to people. Recruitment checks had been carried out appropriately and the home was clean.

People's needs were not adequately assessed or always known to staff. This meant people's needs could not always be met. People gave mixed feedback about the support provided. Staff did not have adequate training and guidance for their roles.

Staff did not always take care to ensure people had enough to eat. People's choking risks were not effectively managed which put people at risk of harm. People gave mixed feedback about the food; some people made and prepared their own meals.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support good practice and we identified a fourth breach of the regulations, around consent.

The provider failed to ensure the service was adapted to meet all people's needs. The service was decorated in a homely way. Staff helped people to access healthcare support.

We identified a fifth breach of the regulations because the provider failed to consistently support people's autonomy, independence and involvement in the community. Institutional practices negatively impacted

on people's dignity, privacy and positive experiences. People were not all encouraged to have control and choice as far as possible.

People were not always well treated and supported, and people's diverse needs were not always met. Staff often had a caring approach, but this was not consistent. People were not adequately supported to have their needs heard and met.

We identified a sixth breach of the regulations because people did not all receive personalised care and were not empowered to have choice and control over their care. People were not involved in care plan reviews, and the views people expressed were not always listened to. Care planning failed to ensure everyone had good access to activities and have their communication needs met. People did not show full confidence in the complaints process.

We identified a seventh breach due to the provider's continued failure to notify CQC of specific events and incidents at the service as required by law.

We identified an eighth breach related to the provider's poor governance systems which exposed people to ongoing risk of harm and poor care. Our inspection found widespread and significant shortfalls in the quality and safety of the service. Systems failed to ensure risks and incidents were appropriately responded to; that there were adequately skilled staff to safely meet people's needs; that regulatory requirements were met and that there were continuous and sufficient improvements to the quality and safety of the service. The provider failed to understand the principles of good quality assurance and failed to act to address serious concerns highlighted through our urgent enforcement activity.

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 Requires Improvement (published September 2018).
At this inspection, enough improvement had not been made and the provider was still in breach of regulations for their continued failure to notify the Commission of specific incidents and events as required. This inspection found the provider was in breach of additional regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
At this inspection, we identified an additional seven breaches of the regulations. This was because the provider failed to provide safe care and treatment and to adequately protect people from abuse and improper treatment. The provider failed to ensure there were enough, sufficiently skilled staff and consent was appropriately sought for the care and treatment provided. The provider failed to ensure people were always treated with dignity and respect and that people always received person-centred care. The provider failed to establish and operate effective systems and processes to ensure compliance with the regulations and to assess, monitor and improve the quality and safety of 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 and carried out a further visit to check what action the provider had taken to ensure people's safety. We found the provider had failed to take enough action to ensure people's safety and we identified additional concerns that continued to place people at immediate risk of harm. We continued to

liaise closely with the local authorities and other relevant partners. We also carried out responsive inspections of other services registered with the provider based on the concerns at this service. Due to the seriousness of our concerns we took further enforcement action to remove this location from the provider's registration. The local authority sourced alternative homes for each person who previously lived at St Andrews Court and this service is no longer active.

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 immediate and urgent concerns we identified. We placed the provider into special measures and carried out urgent and non-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. At the time of publishing this report, the service has been de-registered by CQC.

Special Measures
The overall rating for this service is 'Inadequate' and the service was therefore placed into 'special measures'. We have completed the process of preventing the provider from operating this service by varying the conditions of the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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?

Inadequate

The service was not 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.

St Andrews Court

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
The inspection was carried out by two inspectors, a pharmacy inspector and a specialist advisor. One inspector and a specialist advisor visited the service on 25 September 2019; two inspectors visited the service on 02 October 2019 and a pharmacy inspector visited the service on 03 October 2019. One inspector visited the service again on 16 October 2019.

Service and service type
St Andrews Court 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from 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 also used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who lived at the home and observed the care and support people received.

We spoke with the provider and nine staff members including four senior support workers, two support workers, the deputy manager who had re-joined the service on 16 October 2019, a domestic staff member and another support worker employed at another of the provider's services who was present during our inspection.

We spoke with one visiting professional during our inspection visit and 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 eight people's medication records. We looked at five staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
During and after our inspections, we continued to share information and the concerns we had identified with the local authorities and professionals involved in people's care. We continued to seek updates and assurances from the provider and received some information such as a training matrix after the first day of our inspection.

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 Requires Improvement. At this inspection this key question deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm. We identified three breaches of the regulations because people were not protected from abuse; people's risks including medicines support were poorly managed, and staff were not suitably trained or deployed to safely meet people's needs.

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

- Numerous incidents including alleged abuse of a physical, sexual and verbal nature were not adequately responded to or escalated to relevant partner agencies such as the police and local authority. The provider demonstrated poor awareness of how this failed to protect people.
- Incidents including where people and staff had come to harm were not appropriately learned from and investigated, to help effectively manage risks and prevent future reoccurrences.
- People did not always feel safe. Some people said this was because of incidents at the home. Comments included: "I don't like it here. I don't call it home... Sometimes I get frightened, very frightened," and "Safe here? Yes and no. Sometimes I feel unsafe with the residents."

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.

- The provider failed to respond appropriately to our significant concerns and prompts. We immediately alerted local authorities and liaised with them throughout our inspection processes.
- One person told us they felt safe and secure at the home and enjoyed being independent.

Assessing risk, safety monitoring and management

- One person needed a soft diet to manage their choking risk. None of the staff, nor the provider knew this. This risk had not been identified, assessed or safely managed by the provider. We had to intervene and prevent this person having a meal that was not safely prepared for them.
- Despite our urgent prompts, two weeks on, the provider had still failed to adequately assess this person's choking risk and give staff adequate guidance to support the person safely. Inadequate risk management continued to place the person at risk of choking.
- Risks associated with some people's forensic histories, previous self-harm and suicide attempts were not effectively assessed, managed or always known to staff and the provider.
- Several hazards, including ligature points, were not assessed, reduced and/or removed by the provider. This disregarded people's risks associated with self-harm and suicide. Staff did not know what ligature points were, and were not informed on why these might pose risks to some people.
- Refresher fire safety training was overdue but planned. Staff knew fire safety procedures but were unaware of some people's risks associated with arson and how to mitigate the risk of harm.

● Fire safety risk assessments were not all complete. We made an urgent referral to the fire service during our inspection and continued to liaise with the local authority about our concerns.
● People's risks that were known to staff, were not consistently managed. For example, although staff knew a person was at risk of self-harm and monitored the person at set times, the person had continued access to potentially harmful items throughout the home.

Using medicines safely
● People's medicines administration records (MAR) were written by staff rather than using records printed by the supplying pharmacy. Systems were not in place to ensure this was done accurately to help reduce errors. This was of further concern given the provider's inadequate oversight and management of people's medicines stock.
● Relevant guidance was not available to guide staff on how to safely support people with their 'as and when needed' (PRN) medicines. One person did not have access to their PRN medicine, because staff felt the person would not use this medication.
● Two people's medicines, including controlled drugs were not stored securely and appropriately.
● A homely remedy is a product that can be purchased (for example from a pharmacy or supermarket) to relieve minor ailment(s) without a prescription. People's use of homely remedies was not checked with relevant health professionals to ensure this was safe and suitable.
● Three people needed nurses to manage their medicine dosages, however nurses were not always deployed on shift to consistently provide this care.

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.

Staffing and recruitment
● The provider failed to ensure nurses were always on shift. This meant clinical support, for example to oversee people's mental health and medication support, was not always provided. This was against the provider's agreement with local authorities and the provider's CQC registration. During our inspection processes, the provider arranged nursing cover and commenced recruitment processes.
● Staff gave no responses or inconclusive feedback when we asked if there were enough staff. One staff member told us, "Okay levels on a good day but not on a bad day," for example if there was an incident. We saw there were not enough staff deployed to meet people's needs.
●, We observed one staff member was with seven people during a lunchtime; which included at least two people who required one-to-one support with their meals.
● One person needed to be closely monitored with one-to-one support to help keep the person and others safe. This did not always happen, and staff were not deployed to provide this support. The person was left unaccompanied or with us during one inspection visit.

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.
● Recruitment checks were carried out safely. Records we checked showed nurses had current nursing registrations.

Preventing and controlling infection
● The home was clean. One person told us, "It is clean and tidy. [Staff] keep this place spotless. You won't ever find dust here." We saw domestic staff helped maintain this and people were encouraged to support

with cleaning tasks. Another person told us, "This is nice and clean. There are cleaners every day, this is one of the better places."

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.
At the last inspection this key question was rated Good. At this inspection this key question deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and risks, for example, associated with people's mental health were not always known to staff. Records identified some, but not all people's needs and failed to adequately guide staff on how to provide consistent and effective support at all times.
● During our final inspection visit, it was evident staff had started to read people's care records to refresh their awareness of people's needs. A staff member told us, "We're actually talking about things now… increased mindfulness in team."
● One person's choking risk was not managed and staff did not have enough guidance to provide suitable support. One staff member told us, "[Person] has only been here three weeks," which failed to identify the ongoing risk presented to this person. The staff member confirmed they were only aware of the person's risk because the inspection team had informed them.
● Although people required nursing care, we identified numerous shifts where no nurses had been deployed. This meant care could not always be provided in line with nursing standards.
● People gave mixed feedback about the support provided. One person told us, "Some of the staff are okay but some are not very helpful. If you've got a problem and you ask them, they say go and see [the provider], they don't use initiative."

Staff support: induction, training, skills and experience
● Some people attempted to harm themselves or others when distressed. Despite numerous incidents, staff did not have adequate training to respond effectively, and care plan guidance was poor and incomplete. Staff gave their own interpretations as to how best to support people and were not always compassionate and understanding of people's support needs.
● A staff member from another of the provider's services had been asked to work on site due to staff shortages and was supporting one person. The staff member did not know the needs or risks for this person or anyone else living at the home. This failed to equip this staff member with information to ensure their own safety and to provide effective support. The staff member had unknowingly supported the person to have foods that increased the person's choking risk.
● Refresher medicines and First Aid training was booked as it was overdue for some staff. Overall most staff had current training in other core areas such as health and safety and safeguarding but overdue training had not been identified and addressed in a timely way.

Supporting people to eat and drink enough to maintain a balanced diet
● We saw one person had no meal at lunchtime while others ate. A staff member told us this person had finished their meal. Another person interjected and told us this was incorrect; the first person hadn't been

given any food. Other staff also confirmed this. This showed a lack of regard for ensuring the person had enough to eat.
● Staff did not flag that a number of people had refused meals over one shift, as a potential concern about people's wellbeing or the quality of food provided.
● Another person's choking risk was assessed and known to staff. Staff had provided emergency First Aid on occasions but still did not always monitor the person closely as required.

The provider failed to ensure people were also supported by 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.
● One person told us, "The support is good here, staff have helped me… I needed that help."
● Some people prepared their own meals which promoted their choices and independence. We received mixed feedback about the home's food. One person told us, "Food is alright, good, portions could be better."
● The provider told us there were systems in place to monitor people's weights and food intake.

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.
● The provider and staff lacked understanding of the requirements of the MCA and failed to demonstrate the service worked within its principles.
● A senior staff member told us, "The majority of people have capacity as we keep being told when trying to get DoLS." This did not reflect a service that promoted people's choices and freedom as far as possible.
● The provider and staff prevented some people going out independently although there were no lawful authorisations for these restrictions. The provider had not assessed the concerns they had about some people's safety, to help achieve a balance of people's safety and freedom.
● Some people felt restricted. Two people told us they were not always supported to go out when they wanted to and described the negative impact this had on their mental health.

The provider failed to ensure care and treatment of service users was provided with the consent of the relevant person and that staff understood and met the requirements of the Mental Capacity Act (2005). This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We saw instances where people were offered choices with day-to-day decisions. One person told us they did have freedom to go out and stay out when they wanted.

Adapting service, design, decoration to meet people's needs
● We saw several hazards throughout the premises, including ligature points, which the provider had failed to assess, reduce and/or remove 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. The provider failed to take all reasonable

action to address these concerns despite our prompts.
● Although the provider told us people had been involved in deciding on the décor of the home, people's feedback did not confirm this. One person told us, "I have no say in my room décor… I want more of a place of my own." The service was decorated in a homely way.
● Some adjustments had been made to reduce one person's risk of falls although we advised the provider further steps were needed to complete these improvements.

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support
● A professional involved in one person's care told us, "The staff are very proactive, if there are any concerns they'll phone and let me know, and encourage me to come and have a chat with [person]." This helped promote the person's health and wellbeing.
● People were supported to attend healthcare appointments. People's comments included: "I have [upcoming appointment]. Staff will come with me," and, "They take you to the doctor's, opticians, dentists."

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.
At the last inspection this key question was rated Good. At this inspection this key question deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity and ensuring people were well treated and supported.

Respecting and promoting people's privacy, dignity and independence
● We saw that institutional practices failed to promote people's dignity, privacy and positive experiences. People were instructed to come to the clinic room for their medicines in alphabetical order of their surnames. Records showed one person was frustrated by this arrangement and had accordingly refused their medicines on some occasions.
● In another example, people were given cigarettes at set times. One person needed emergency support from staff because they choked on their meal due to rushing for their cigarette. Staff failed to review the arrangements in place following this incident and people still had set times allocated.
● One person told us, "I'd like to go out, do things, I can't get out… Today I was allowed to go out… Life is for living and I can't go out. You don't go out a lot here… I would get to exercise… go out and see people, mix, blend." The person was very distressed about their wish to go to church; and very emotional and relieved after we asked the provider to assist them to do so.
● Another person told us, "I have to get up at 08.30am. Otherwise you miss breakfast. You can't have a lie in here. I don't know why. it's not like your own home. This is an institution really... My fingers are crossed I can go and live like my family."

The provider failed to support all people's autonomy, independence and involvement in the community. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● People were encouraged to carry out daily living tasks to promote their independence. One person told us, "We have a rota, we take it in turns to mop floors and clean the dining room."
● Another person told us they were given privacy at the home. There were different spaces and lounges where people could spend their time.

Ensuring people are well treated and supported; respecting equality and diversity
● One person sometimes lay on the floor when distressed. Staff were supposed to reassure and support the person in twos to stand up. We saw this did not happen. One staff member told us, "I've found the best way is to ignore [person], the more we try to get [person up], the more [person] stops there." The provider told us they would address this with staff.
● The provider gave examples of how some people's cultural needs were met. However, care planning processes failed to always consider and meet all people's individual needs, for example, people's language and communication needs. Staff did not always demonstrate sensitivity towards, and understanding of people's individual needs and differences.
● People gave mixed feedback about staff. One person told us, "[Staff] treat you like children, they don't

treat you like an equal they look down on you." Another person told us, "Staff are not too bad. Could be better. Could be worse… I think the staff have been nice to the other people that live here." A third person told us, "All the staff are the same. They are all caring."

● We saw staff were often courteous and had a caring approach towards people, but this was not consistent. Staff were sometimes impatient with people; one staff member was sharp in their tone towards a person and gave them blunt instructions. The provider saw this but did not intervene and address this concern.

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

● Residents' meetings were held to provide people with the opportunity to share their views about the service and their care. However, people's views were not always adequately responded to, for example people's concerns about medicines support.

● We saw poor practice where one person's views were not listened to. We saw a staff member asked one person, "What is wrong with your meal". The person said they wanted an alternative option. The staff member replied, "Oh are you just asking if we have any. Yes. I will check after lunch." This response ignored the person's request.

● People had attended review meetings with relevant healthcare professionals to discuss their health and wellbeing. However, people did not have regular opportunities to discuss their individual care needs. The provider and staff knew two people wanted to leave the home but could not demonstrate how this feedback had been acted on.

● One person felt well supported and involved in their care. They told us, "Before I [joined the home], all my records were sent… me and [the provider] sat and talked about [them]... If I ever don't feel right all I do is knock her door and [the provider] makes time for me."

Inadequate

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 deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Care reviews were not held to involve people in their care and ensure care always met people's needs and preferences. The service was set up to provide rehabilitative support and help people achieve personal outcomes. The systems in place did not enable this to happen and people did not feel involved in the planning of their own care.
- Support we saw, and the routines of the home did not demonstrate people were treated as individuals. Care records contained generic, incomplete guidance for example about people's risks and did not refer to people's abilities, interests and positive outcomes for their care.
- One person told us they had not been given a response when they asked the provider if they could move on from the service. The person asked us to follow up on this. The provider could not demonstrate how they had assisted with this person's wishes and future goals.
- The provider failed to make use of information shared by other professionals involved in people's care to assess whether people's needs could be met, and how. During our inspection, the provider decided they could not meet the needs of a recently admitted person. They failed to take enough action to manage the person's risks while the person remained at the home and told us this was because the person was moving on.
- In the residents' meeting records, we saw one person had been denied foods that staff, and the provider deemed unhealthy. Five months later during our visit, the person said they were still not allowed this food. This meant staff were not ensuring people could make their own choices based on their personal preferences.
- We received mixed feedback about the service. Some people expressed they wanted to leave; one person told us, "I don't like it here. I don't call it home." Other people said their mental health had improved over time at the home. One person told us, "[The provider] helped me when I was drowning."

The provider failed to ensure people received person-centred care and treatment that is appropriate, and according to people's needs and personal preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- The provider did not demonstrate understanding of their responsibilities related to this standard. The provider told us nobody required information to be presented in a different form and confirmed no such

support was in place. We prompted the provider to consider the needs of people living at the home, including one person with a visual impairment and another person who could not always express their needs verbally.

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

● One person told us people were offered things to do. We saw one person listened to music.

● We saw no activities offered however throughout inspection visits. We often saw some people moved from one area of the home, to another and again, with little else to do.

● Some people went on holiday together during the summer. A professional told us, "[Person] had a holiday for the first time and loved, it, [person] has never had it so good."

● One person told us their family regularly visited them. Two people told us they could come and go when they pleased but that they had curfews.

● We asked staff what was positive about the home and they told us, "The people here are happy to be here, we chat with them, we associate with them."

Improving care quality in response to complaints or concerns

● The provider told us there had been no complaints.

● People we spoke with did not show full confidence in the provider's complaints processes. One person told us, "I've never complained, there is no point in complaining, nothing gets done, it just sweeps under the carpet." Another person told us, "I would complain if I needed to, I would go to [the provider] if troubled. I said to [the provider] the place was not run properly, and she didn't say anything back. [The provider] doesn't really say anything."

● People were informed of the complaints process, for example during residents' meetings and in response to home surveys. People had been given information about advocacy services. However, this guidance was not available in accessible formats to help meet all people's needs.

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 Requires Improvement. 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; 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

- We found widespread and significant shortfalls in how incidents and risks were managed which placed people at continued risk of harm and poor care. The provider failed to make effective use of information shared by professionals. Risks identified through incidents at the home were not reviewed in order to improve the safety of the service.
- The provider failed to deal with allegations of abuse appropriately and referred to one allegation of abuse as, "A terrible thing to say about [alleged perpetrator]." We had to prompt the provider a number of times to make another safeguarding referral about abuse raised with staff; the provider disputed this was their responsibility. This failed to protect people and staff.
- We received mixed feedback about the service's leadership. One person feared repercussions for giving us feedback about the service and told us, "If you get on the wrong side of [provider], she will have you in the office. If you've done something wrong, if the staff complain about me, you go in the office… She will make my life hell." We saw documented occasions people had been brought to the office due to the provider's concerns; our discussions found the provider did not consider this to be inappropriate.
- The provider failed to meet the requirements of Duty of Candour and to protect people in their care from harm. Incidents were not reported and escalated as required.

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

- We saw numerous and regular occasions where nurses had not been deployed on shift. This prevented people's access to the nursing care and clinical support they required.
- The provider could not demonstrate the service always operated according to agreements with the local authority in relation to nursing care, and to support one person's adherence with conditions set out by the Ministry of Justice.
- Systems failed to ensure people's needs and risks were known to staff. A staff member who was responsible for updating people's care plans, told us, "It's been two years since I read the folders… I don't read the whole care plan." The staff member told us they knew about one person's choking risk because the inspection team had brought it to their attention.
- At the last inspection in August 2018, we identified a breach of the regulations because the provider had not notified the CQC of specific incidents and events as required. The provider demonstrated poor learning from this and remained in breach of the regulations.
- We identified numerous further events and incidents that the registered provider had failed to notify CQC

about, for example, where people and staff had made allegations of abuse.

The provider had failed to notify CQC of all incidents that affect the health, safety and welfare of people using the service. This 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.

Continuous learning and improving care

● In recent weeks, a person living at the home had pushed a staff member up against a wall. The provider told us some incidents involving this person were unpredictable and, "Just bad behaviour". However, the provider had not analysed any incidents for potential trends and patterns and had failed to identify signs of poor health and triggers for this person.

● The provider advised they did not refer to current good practice guidelines to help monitor and improve the quality and safety of the service. The provider did not demonstrate they had their own adequate systems in place to achieve this.

● 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 risk of harm and poor care.

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.

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

● Staff told us they felt supported and spoke positively about the provider.

● People's feedback was sourced for example through surveys and residents meetings, but this was not effectively used to improve the quality of the service and people's experiences.

Working in partnership with others

● Health professionals often spoke positively about the service. The local authority engaged with the provider during our inspection and enforcement processes.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider failed to ensure people received person-centred care and treatment that is appropriate, and according to people's needs and personal preferences.

The enforcement action we took:

We served urgent conditions regarding these serious concerns and we varied the provider's registration to remove this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider failed to support all people's autonomy, independence and involvement in the community.

The enforcement action we took:

We served urgent conditions regarding these serious concerns and we varied the provider's registration to remove this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider's systems failed to protect people from abuse and ensure any allegations of abuse were immediately investigated.

The enforcement action we took:

We served urgent conditions regarding these serious concerns and we varied the provider's registration to remove this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	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:

We served urgent conditions regarding these serious concerns and we varied the provider's registration to remove this location.

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

The enforcement action we took:

We served urgent conditions regarding these serious concerns and we varied the provider's registration to remove this location.

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 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:

We served urgent conditions regarding these serious concerns and we varied the provider's registration to remove this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	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:

We served urgent conditions regarding these serious concerns and we varied the provider's registration to remove this location.