Hadley Place Limited

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

Summary of findings

Overall summary

About the service
Hadley Place Residential Home is a care home providing personal care for up to 29 older people who may be living with mental health needs or dementia. The service was supporting 20 people at the time of our inspection.

People's experience of using this service
People were at risk of harm as risks to their health, safety and wellbeing were not effectively identified and managed. There remained widespread and significant concerns about the quality and safety of the service, which had not been addressed since our last inspection.

The service was unclean and not properly maintained. Risks associated with the environment had not been addressed in a timely way to help keep people safe. Robust systems were not in place to ensure the service was regularly and thoroughly cleaned or to effectively reduce the risks of people catching and spreading COVID-19.

People raised concerns about staffing levels, the provider's dependency tool did not provide assurances that staffing levels were effectively monitored. Appropriate fire drills had not been completed to check and make sure night-time staffing levels were safe and people could be safely evacuated if there was a fire at night.

Accidents and incidents were not effectively reported, recorded and responded to. This put people at increased risk of harm.

People received their medicines as prescribed, but further improvements were needed to ensure medicines were consistently managed and administered safely.

Robust systems were not in place to check and make sure all staff were suitably trained and competent.

People's needs were not robustly assessed and regularly reviewed. Care plans and risk assessments did not always reflect people's needs, risks or provide up-to-date information to guide staff on how to safely support them.

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

People did not receive person-centred support to engage in regular meaningful activities to reduce the risk of social isolation. Any wishes or views people had for their care and support approaching the end of life wishes were not always explored and recorded.

The service was not well-led. There were continued widespread concerns about the quality and safety of the service. The provider had failed to take sufficient and timely action to address safety issues and to make improvements, which would help keep people safe and improve their quality of life. There was a lack of effective oversight and governance.

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk.

Rating at last inspection and update
The last rating for this service was inadequate (published 8 June 2021) and there were multiple breaches of regulation.

At this inspection not enough improvement had been made and the provider was still in breach of regulations. The service remains rated inadequate. This service has been rated requires improvement or inadequate overall for the last five consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at our last inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches in relation to person-centred care, dignity and respect, consent to care, safe care and treatment, the environment, staffing, and the provider's governance arrangements. Please see the action we took at the end of this report.

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 effective. Details are in our effective findings below.	**Inadequate**
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**

Hadley Place Residential 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. 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors and a medicine inspector.

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

The service did not have a manager registered with the CQC. The registered manager along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The service had been without a registered manager since February 2018. The last registered manager had been reemployed and was managing the service. Following our site visit, they withdrew their application to become registered manager and left the service.

Notice of inspection
The first day of our inspection was unannounced. The second day of our inspection was announced.

What we did before the 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 used all this information to plan our inspection.

The provider was not asked to complete a provider information return before 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 seven people who used the service about their experience of the care provided. We spoke with the business support administrator, two senior care workers, the maintenance person, a cleaner and the cook.

We reviewed a range of records. This included 16 people's care records and nine people's medication administrations records. We inspected two staff files in relation to their recruitment, induction, training and supervision. A variety of other records relating to the management of the service, including audits and policies and procedures, were also reviewed.

We inspected the environment and spent time observing staff's interactions and infection prevention and control practices.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We requested and reviewed additional records including care records, audits, training data, staff rotas and other records relating to the management of the service.

We spoke with three people's relatives, two members of care staff, the manager and the provider's 'nominated individual' by telephone. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received feedback from three professionals who worked with the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection this key question was rated inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

At our last inspection the service was not clean and infection prevention and control risks were not effectively managed. This was a breach or Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- People were at risk of catching healthcare related infections. The service was unclean and infection prevention and control risks were not adequately managed.
- Robust systems were not in place to make sure all areas of the service were regularly and thoroughly cleaned. Flooring, furniture and surfaces throughout the home were unclean and showed evidence of ingrained dirt.
- People were not protected against the risks associated with COVID-19. Appropriate checks were not completed on visitors to the service; staff did not always use personal-protective equipment appropriately and safely. Adequate cleaning was not completed to reduce the risk of people catching and spreading COVID-19.

The failure to ensure good infection prevention and control systems were in place put people at risk of harm. This was a continued breach or Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to assess and manage risks to ensure the health, safety and wellbeing of people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- People were at risk of receiving inappropriate or unsafe care. Risk assessments did not always contain up-to-date information about people's needs, risks or to guide staff on how to safely support them.
- Risks associated with people using the stairs had not been adequately assessed to ensure they were safe.

Accommodation was provided over four floors and there was unrestricted access to the stairs throughout the building. Falls from stairs can result in serious or fatal injuries.
● A robust system was not in place to ensure accidents and incidents were appropriately reported, recorded and managed. This meant there were delays in making sure appropriate action had been taken and any lessons learned.

Whilst we found no evidence people had been harmed, the failure to adequately assess and manage risks put people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection we recommended the provider review how people's dependency levels are assessed to accurately inform the staffing numbers and deployment on shifts. Not enough improvement had been made at this inspection.

● People gave mixed feedback about staffing levels. Comments included. "They could do with more staff they always seem busy" and "Staff are busy, I don't think there is enough staff to be able to sit and talk with us."
● Staff were busy, and because of this, interactions were often brief and task based. There was limited time for staff to spend with people and provide meaningful stimulation.
● The provider used a dependency tool to help make sure enough staff were deployed, but this did not evidence a thorough assessment of people's needs, was not always accurately completed and did not provide insight into how staff should be deployed across a 24-hour period.
● Appropriate fire drills had not been completed to check and make sure two staff could safely evacuate people if there was a fire at night.
● Recruitment checks had been completed to help make sure suitable staff were employed. However, there were some gaps in these records. This meant we could not be certain the provider had followed a robust and safe recruitment process.

The failure to make sure sufficient numbers of staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection people did not receive their medicines as prescribed placing them at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of requirements relating to the management of medicines under Regulation 12.

● People's medicines were administered as prescribed; the quantity of medicines stocked was recorded upon receipt and then balances checked regularly, which meant we could be sure medicines had been administered as recorded by staff.
● However, good practice guidance had not always been followed, which showed further improvements were needed to ensure medicines were consistently managed safely. For example, robust checks had not been completed to make sure all staff responsible for administering medicines could do so safely. There

were no records of people's preferences to indicate how they wanted their medicines to be administered.
● Temperature records to ensure the safe storage of medicines were not always completed in accordance with national guidance.
● Guidance specific to each person on how to administer 'as required' medicines had been updated since our last inspection, but staff did not always clearly record if this medicine was refused or not required.

Systems and processes to safeguard people from the risk of abuse

At our last inspection people were unlawfully deprived of their liberty. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach Regulation 13.

● People were lawfully deprived of their liberty where necessary. Appropriate applications had been submitted to ensure staff had the legal authority to keep people at Hadley Place Residential Home when this was in their best interest.
● People felt safe with the care and support staff provided. Staff completed safeguarding training to help them identify and report any safeguarding concerns.

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 our last inspection this key question was rated inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

At our last inspection the premises were not properly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 15.

● The service was not suitably adapted to meet people's needs or improve their quality of life; areas of the service were impersonal and did not provide a homely or 'dementia friendly' environment. A professional told us, "It is one of the least pleasant environments I have visited."
● The provider had not maintained a suitable and safe environment. Significant areas of the service needed renovation. Paintwork, flooring, furniture and equipment were damaged, worn or needed to be replaced.
● People were not protected from the risks of passive smoking. There was a strong smell of cigarettes in communal areas of the ground floor. The 'smoking shelter' was not properly designed to prevent second-hand smoke entering the building.

Failure to ensure the premises were suitable and properly maintained was a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to assess people's needs effectively. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

● People were at risk of receiving ineffective or unsafe care. Care plans and risk assessments did not always

provide up-to-date information about people's needs or to guide staff on how those needs should be met.
● Robust systems were not in place to monitor and make sure people's needs had been met. For example, records did not evidence a person was supported to regularly change their position to reduce the risk of developing skin damage.
● Two people with skin damage did not have up-to-date care plans and risk assessments to guide staff on how to support them and help monitor the problems with their skin integrity.
● Staff had not sought timely advice from healthcare professionals to meet a person's continence needs.
● Detailed and clear information was not always recorded about involvement from healthcare professionals and any advice or recommendations they made.
● People did not receive effective care and support to help make sure they ate and drank enough. There were gaps in records around the support staff should be providing at mealtimes. Staff had not recorded and monitored what people drank where necessary.
● People were not always offered choices at mealtimes and records did not always show people were offered regular drinks and snacks throughout the day.
● People had been put at risk of receiving unsafe care and support as their care plans did not always contain accurate and up-to-date information about their dietary needs.

Failure to assess and effectively meet people's needs was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At our last inspection people's consent to care was not sought in line with the MCA. This was a breach or Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

● People's ability to consent to their care and support was not always adequately explored and recorded. This meant we could not be certain people's human rights were protected.
● The service was not following the principles of the MCA and associated guidance. There was a lack of records to show people's mental capacity had been appropriately assessed or to evidence decisions made on people's behalf were in their best interests.

The failure to ensure consent to care was explored and recorded in line with the MCA and associated guidance was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had not ensured staff were sufficiently trained and competent. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● People were at increased risk of receiving ineffective or unsafe care as a robust system was not in place to make sure all staff were suitably skilled and competent to meet people's needs.
● Observations and competency checks had not been used effectively to check and make sure staff understood good practice guidance and were supporting people in a safe way. For example, in relation to staff's use of personal protective equipment or for night staff administering medicines.
● Staff had completed a number of training courses since the last inspection including around supporting people who may be living with complex mental health needs. However, there remained gaps in some staff's training.
● Not all staff had completed fire drills or evacuation training to check and make sure they understood what to do in an emergency.

The failure to make sure staff were suitably competent and skilled was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff felt the new manager was approachable and supportive. The manager explained they had spent time working with staff to provide guidance and mentorship and support good practice.
● The manager had completed some supervisions and appraisals since starting at the service, but this system was not embedded and did not show a robust approach to monitoring, supervising and supporting the continual professional development of staff.

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 our last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection the support provided did not maintain people's dignity. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 10.

● People's dignity was not always maintained. Whilst individual staff were kind and caring, the provider's approach to the cleanliness and maintenance of the premises showed a lack of regard for people's dignity.
● Some people's bedrooms smelt of urine and we were concerned about the support provided to meet one person's continence needs. This did not maintain their dignity.

The failure to promote dignity and respect was a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
● Due to the widespread and ongoing concerns identified during this inspection, we could not be assured people received a high-quality, compassionate and caring service. We have taken these concerns into account when rating this key question.
● People gave generally positive feedback about the individual staff who supported them. Feedback included, "Staff look after me. They are lovely people" and "They are really friendly and caring." A professional explained, "The staff I've met have been very compassionate and they aim to keep people's dignity."
● Staff were kind in the way they spoke with people and we observed some positive interactions between staff and the people they cared for. However, staff were busy, and interactions were often brief, and task based. Staff did not sit and talk with people for a meaningful length of time.
● People's confidentiality was not always maintained; information was not securely stored in the manager's office to prevent unauthorised access.

Supporting people to express their views and be involved in making decisions about their care
● People were not always offered choices and did not receive effective support to help them make

decisions. For example, at mealtimes people were not always offered a choice of what to eat, menus were not used to help people decide what to eat and people were not shown options to help them choose.

● Robust systems were not in place to check and make sure people were involved in decisions wherever possible. This meant we could not be certain people had been supported to express their views or that their wishes were considered in decisions about their care.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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; 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; End of life care and support

At our last inspection people's care and support needs were not always identified and met. This was a breach of Regulation 9 (Person- centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

- People's care and support was not planned and delivered in a person-centred way. Staff did not always have up-to-date information about people's needs and how best to support them.
- Care plans and risk assessments were not always regularly reviewed and updated as people's needs changed. Updated care plans had not been put into use in a timely way. This increased the risk of people receiving unsafe care which did not meet their needs.
- People told us they were not involved in developing their care plans or in regularly reviewing these. Records did not always show people had been involved in making decisions and planning how their needs would be met.
- People did not have end of life care plans, and staff had not always explored and recorded any wishes or views people had about their care and support approaching the end of their life. This meant people's preferences and choices may not be known to staff.
- People were not always encouraged and supported to engage in regular and meaningful activities. There was limited and inconsistent support provided to reduce the risk of social isolation.
- The provider employed activities coordinators, but their input was limited, and cover had not been arranged if they were away from work.
- People told us staff were often busy; staffing levels meant there was little time and opportunity for staff to support people with activities or to provide regular and meaningful stimulation.
- Records did not evidence people were offered the opportunity to take part in regular activities or consistently supported to pursue their hobbies and interests.

The failure to adequately assess people's needs and plan their care and support in a person-centred way was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person's relative provided positive feedback about the kind support staff had provided to a person at the end of their life.

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.
● People's care plans contained some information about their communication needs and to support staff to share information in an accessible way.
● Staff used some accessible information, but we spoke with the manager about ways to develop their approach and to embed the use of accessible information into staff's practice.

Improving care quality in response to complaints or concerns
● There was limited evidence to show people were asked for their feedback or to show how their wishes and views were considered and used to improve the quality of their care.
● We were told there had been no complaints about the service since the last inspection. The provider had a complaints procedure setting out how they would manage and respond to any complaints about the service.
● People said they would speak with their relatives or staff if they were unhappy about the service or needed to complain.

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 our last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the service was not consistently and effectively led. People were at risk of receiving poor quality care, because robust quality assurance systems were not in place. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● People were at risk of harm, because the service was not well-led. There were significant and widespread concerns about the quality and safety of the service. The environment was unclean and there were widespread issues relating to the upkeep and maintenance of the service.
● Risks, issues and concerns were not always identified and addressed in a timely way. The provider had failed to take adequate steps to address safety concerns and to make improvements, which would help keep people safe and improve their quality of life.
● Clear and complete records were not always available. Information about people's care, risks and the management of the service was incomplete or missing meaning there was a lack of transparency about how the service was managed.
● Audits and the provider's governance arrangements were ineffective and had failed to adequately address concerns and drive improvements. Significant concerns identified at the last inspection relating to the quality and safety of the service had not been addressed.
● This was the fifth consecutive inspection where the service had been rated requires improvement or inadequate overall and there were multiple continued breaches of regulations. This showed a systematic failure in the provider's organisation and leadership of the service.
● The service had been without a registered manager since February 2018. A new manager was in post, but following our site visit, they withdrew their application to become registered manager and left the service. The provider told us they were working to make improvements, but we were concerned about the lack of improvements since the last inspection. Significant action had not been taken to address known issues and make improvements to keep people safe and improve their quality of life.

The failure to assess, monitor and mitigate risks and take adequate steps to improve the quality and safety

of the service was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had not notified CQC of all events which had occurred within the service as legally required to do. This was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach Regulation 18.

● Regular notifications had been submitted to CQC. One notification was submitted during the inspection for an authorised deprivation of liberty, which CQC had not been notified of.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Whilst people generally told us they were happy at the service and with the care staff provided, the provider did not have robust systems in place to make sure people received consistently high-quality, person-centred care.
● There was limited evidence to show people's views or experience of using the service were considered in the way the service was run.
● The provider had not worked effectively in partnership with others to make necessary improvements. The service had received support from the local authority and other healthcare professionals to make improvements to the quality and safety of the service. Despite this input, progress to make improvements was inconsistent and not always sustained.
● The widespread issues and concerns identified during this inspection did not support people to achieve good outcomes or improve their quality of life.

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 People's care and support was not planned and delivered in a person-centered way. Regulation 9(1).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. Regulation 10(1).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care provided had not always been sought. The provider had not acted in accordance with the Mental Capacity Act 2005. Regulation 11(1).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed risks to the health and safety of service users or done all that is reasonably practicable to mitigate risks. Regulations 12(1).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not clean, suitable for the purpose for which they were being used or properly maintained. Regulation 15(1).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established and operated effectively systems or processes to assess, monitor and improve the quality and safety of the service and to mitigate risks. They had not maintained securely accurate, complete and contemporaneous records. Regulation 17(1).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably trained and competent staff had been deployed. Regulation 18(1).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.