McLaren House Limited

Rowena Court

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
Rowena Court is a care home which is registered to provide personal care for up to six people with mental health needs. There were six 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 using the service, we found people were not protected from the risk of harm and abuse. The provider failed to appropriately escalate allegations of abuse, including where current staff were named as alleged perpetrators. Staff were not trained and equipped to respond appropriately to suspicions of abuse. This was a breach of the regulations.

We identified a second breach of the regulations due to the inadequate management of people's risks, including poor learning from incidents at the home. Medicines management systems failed to ensure people would always be safely supported.

The provider started to improve recruitment processes after our inspection and staff felt staffing levels were safe. The home was clean and further improvements were underway, prompted by the local authority, to ensure good infection control.

We identified a third breach of the regulations because staff did not have adequate training and guidance to carry out their roles effectively, and staff deployment was not appropriately managed. We identified a number of shortfalls in how people's needs were assessed in addition to a lack of training for staff. People were supported to access healthcare support, but this guidance was not used to appropriately inform people's care. This all prevented adequate, effective support being provided to always meet people's needs.

Although areas of the service were homely, the design and décor of the service failed to show regard for all people's needs.

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 policies and systems in the service did not support this practice.

Although we saw some positive interactions with people from staff and people spoke positively about staff, established routines at the home, and the provider's poor oversight such as their response to incidents, failed to ensure people were always well supported. We found concerns that compromised people's dignity, respect and positive experiences. People did not have routine and planned opportunities to discuss and review their care to ensure this always met their needs.

We identified a fourth breach of the regulations as established routines at the home failed to ensure people's individual needs and wishes were always taken into account. Furthermore, care planning

processes failed to identify all people's needs were appropriately identified and met including communication needs and end of life support.

People had been advised how to complain but no formal complaints had been submitted. People were supported to maintain community links and were encouraged to do some group activities at the home.

We identified a fifth breach of the regulations due to the provider's poor governance systems which failed to adequately assess, monitor and improve the service. We found widespread concerns which had not been identified and addressed and which the provider had failed to notify relevant partner agencies as required. We identified a sixth breach of the regulations because the provider did not meet their legal requirement to notify CQC of specific incidents and events. Despite our urgent prompts during inspection and enforcement activity, the provider failed to act on the serious concerns we brought to their attention which placed people at ongoing risk of harm and failed to protect staff.

Rating at last inspection
The last rating for this service was Good (published March 2018).

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 two services 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
At this inspection, we identified six breaches of the regulations. 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. The provider failed to ensure there were sufficient numbers of suitably skilled and competent persons deployed to safely meet people's needs, including that staff received appropriate support and training. The provider failed to ensure people received person-centred care and treatment that met people's needs and personal preferences. The provider failed to notify CQC of all events and incidents as required and failed to operate effective systems and processes 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. 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.

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 immediate and urgent 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 of 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 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**

Rowena 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
This inspection was carried out by two inspectors.

Service and service type
Rowena 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. The provider attended the inspection for a short time.

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 five people who lived at the home and observed the care and support people received. We met briefly with the provider and we spoke with six staff members including the deputy manager, two senior support workers and three support staff members. 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 one person'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 local authorities and professionals involved in people's care. We continued to seek updates and assurances from the provider including through formal requests concerning the quality and safety of the service. We also requested evidence about recruitment processes related to three 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

- People told us they felt safe and happy at the home, however numerous incidents and potential safeguarding matters had not been appropriately responded to, to always protect people and staff.
- This included allegations of physical and financial abuse with current staff named as the alleged perpetrators. The provider failed to take action to protect people and staff at the time of those allegations and despite our urgent prompts, to do so on inspection.
- Most staff did not have current safeguarding training and were not all informed on how to identify and escalate safeguarding concerns effectively to help protect people.

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.

- We took urgent enforcement action and raised our concerns with the local authority.
- People told us they felt safe. One person said this was because of the home's friendly atmosphere and commented, "I've never felt in danger or worried."

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

- Incidents were not appropriately reviewed, escalated and learned from. Records showed one person had choked on food 'in the past'. We found the person's choking risk was still not managed safely and staff were not adequately trained to assist the person should they start to choke again.
- People were placed at risk of harm because risks were not all adequately assessed and managed. One person's daily vitals checks showed their readings met and then fell beneath safe levels on three occasions in one week. We asked what had been done to help ensure the person was well and safe and found these concerns had not been identified or acted on.
- Staff did not have shared understanding of people's risks and how to support people safely. Assessments and guidance for staff about people's risks were incomplete and did not ensure people could always be kept safe.
- Staff did not have adequate fire safety training and guidance to ensure they could respond appropriately in the event of a fire.

Using medicines safely

- People's medicines records were written by staff yet systems were not in place to ensure this was always done clearly and accurately. Stock level checks were not routinely carried out. Together this increased the risk of medicines errors, and reduced the likelihood that medicines errors could be promptly identified.
- Only a minority of staff had current medicines training and competency checks were not done to ensure

staff knew how to support people safely.
● Relevant processes were not followed to ensure safe support at all times, for example for people's use of 'as and when' medicines and creams.

The provider failed to adequately assess and mitigate risks to people's health and safety, including risks with the management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We saw staff supported people appropriately, for example to offer people a drink and ensure people took their medicines. One person told us they got their medicines on time.

Staffing and recruitment
● 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. Staff did not support one person adequately with their meal although this was required due to the person's choking risk and although there were enough staff present to provide this support.
● Staff had not received appropriate support and training for their roles to understand and to safely meet people's needs. This included people's physical health needs which put people at immediate and ongoing risk of poor and unsafe care.
● Staff carried out regular checks of people's vitals without training or guidance to ensure staff did this safely and were able to pick up concerns from these checks.

The provider failed to ensure there were sufficient numbers of suitably skilled and competent persons deployed to safely meet people's needs including to ensure persons employed received appropriate support and training. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Staff felt there were enough staff on site especially as some people went out during the day. We saw staff had enough time to support and spend time with people.
● A staff member told us, and records showed recruitment checks were carried out before staff started their roles. After the inspection, the provider completed an audit of their recruitment processes to check these were safe because these processes had not always been appropriately documented.

Preventing and controlling infection
● Improvements were underway following a recent infection control site visit by the local authority.
● The home was clean.

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 as 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; Supporting people to eat and drink enough to maintain a balanced diet

- Although people told us staff supported them well, people's identified needs were not all adequately assessed. For example, care plans and sufficient guidance were not available for one person's known choking risk and two other people's healthcare conditions.
- Staff believed one person should have their fluid intake restricted, but gave mixed answers about the reasons for this, and how much the person could safely drink. This risk was not clarified or effectively monitored. Staff gave mixed reasons as to why they did not monitor the risk for example that it frustrated the person and it was difficult to do. The person received poor support which caused them distress. These concerns had not been assessed or reviewed further.
- People were subjected to regular checks such as blood sugar level monitoring which had not been prescribed by a health professional. Staff had not received training and guidance about how to do these checks appropriately.
- One person's needs associated with dementia were not assessed and met as far as possible. Staff did not have access to training or guidance about dementia care.

Staff support: induction, training, skills and experience

- Only one staff member had received the provider's mental health training and less than half of the staff had received 'Challenging Behaviour' training. Records showed the majority of staff training in other core areas was outdated or had not been provided, including Health and Safety and Infection Control. Staff told us they had received recent training updates in moving and handling and food hygiene.
- Staff were instructed to monitor one person while they ate due to the person's choking risk. We saw staff failed to do this, including an occasion that the person was given high risk foods which increased their risk of choking. Staff did not know this food could increase choking risks.
- After our inspection, the provider told us they would arrange training to address people's specific risks and requirements including around nutritional and hydration needs. It was of significant concern this action had not already been taken without our prompts.
- This combined with the provider's inadequate risk assessments and records failed to ensure staff were equipped with the skills and knowledge to provide effective support at all times.

The provider failed to ensure persons employed received appropriate support and training and were suitably skilled and competent 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.

● Some people felt their needs were well met. One person told us, "[Staff] would look after you," if they did not feel well.
● People all told us the food was good and they were offered meal choices. Some people were supported to prepare their own meals and drinks.
● Some staff showed good awareness of some people's healthcare needs. Staff told us they did shadowing and an induction when they joined the home.

Adapting service, design, decoration to meet people's needs
● A staff member told us they removed some hazards as they were mindful some people could harm themselves. However, we saw numerous potential hazards throughout the premises, including ligature points, accessible cables and discarded furniture. One person had hurt themselves in their bedroom but told staff they did not know how. These risks 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 mental health needs and falls risks. In another example, one person told us they did not like the Hallowe'en décor and that they had not been asked about this décor before it was displayed.
● Other areas of the service were decorated in a homely way.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● We saw evidence that healthcare advice was sought with and/or on behalf of people living at the home. However, advice received from professionals was not always clearly reflected in people's care plans to ensure consistent and informed care was always provided.
● Where staff were unsure about some people's needs, this had not always been followed up with healthcare professionals to ensure people always received effective care from staff.

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.
● We saw staff gave people choices to help people make basic decisions, however some people were subject to restrictive support, such as their wardrobes being locked. A staff member told us this was because the person put wet and dirty laundry in their wardrobe.
● In another example, staff had concerns about one person's safety out in the community and chose to prevent the person always going out on their own. This was not assessed or explored further with the person to promote the person's choices and independence as far as possible.
● Staff showed poor or no awareness of the MCA and its requirements and if any people had DoLS authorisations in place and why. The majority of staff had not completed relevant training.
● One person's records showed they had fluctuating capacity but there was no guidance as to what decisions the person could not make independently, and how to support the person to make their own

decisions otherwise as far as possible.

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; Respecting and promoting people's privacy, dignity and independence

- We saw some positive interactions with people from staff and people spoke positively about staff. However, established routines at the home, and the provider's poor oversight such as their response to incidents, failed to ensure people were always well supported.
- We found some established means of supporting people failed to promote people's dignity as far as possible. Staff told us one person often became distressed and aggressive because staff restricted how much the person had to drink. This included the person cupping water to drink from a bathroom tap because they were so thirsty. Despite this, the person's risks and staff practice had not been reviewed to promote the person's dignity and to minimise this person's poor experiences.
- One person was given foot care by staff in a communal area where other people spent time, and where people later ate their meals. When we discussed this with the staff member, they recognised this practice did not promote people's dignity or good hygiene and infection control.
- Incident records showed occasions of verbal altercations such as shouting and name calling between people living at the home. Although staff encouraged people to get on, these incidents had not been reviewed further for potential themes and patterns to prevent future reoccurrences.
- People's care plans did not identify their individual needs, for example related to culture, religion and relationships. Only one staff member had current training related to equality and diversity needs. Staff told us some people attended religious services.
- One staff member did not always speak respectfully about one person which reflected the staff member's poor understanding of their role. However, generally we saw positive staff interactions with people.
- Staff described how they gave emotional support to people and helped promote people's privacy and dignity. Some people's feedback reflected this. One person commented, "Staff are really nice, they support me well. They make sure you are safe, listen to me." Another person told us they were able to have a laugh and a nice time with a staff member they got on well with.

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

- A staff member told us, "We have residents' meeting once a month. We're here at any time if [people] want to speak to us. There are no set times… but we check [how people are]."
- People did not have regular opportunities such as care reviews, to identify and discuss their individual care needs and to ensure care and treatment could always be tailored to people's needs and preferences.

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

- A person living with dementia told us they struggled with puzzles. We asked staff what activities could be sourced to better suit the person's needs. The staff member told us, "We aren't dementia." The provider did not offer an alternative response. This failed to acknowledge the person's needs and ensure they could always be well met.
- People were asked what they wanted for lunch, the evening before. We asked if this practice could be reviewed to better support a person living with dementia who could not remember their choice. Staff said no and told us this was because the person would not remember their choice because the person was always sleepy. This was not a clear or adequate response from staff and showed a lack of regard for the person's support needs and failure to help promote the person's choice and control as far as possible.
- Staff told us people could approach staff or use residents' meetings to discuss people's care. This did not give people individual and private opportunities to discuss their care, to help assess and ensure the care and treatment provided always met people's needs and preferences.
- We were told by staff that people living at the home were subject to blood pressure monitoring checks although staff did not know if and why these checks needed to be done. Although this was routine, regular practice at the home, there was no evidence this had been reviewed and people had been consulted on this support, although checks were known to cause one person anxiety. After our inspection, the provider told us this support was needed due to some people's physical health conditions and prescribed medication.
- Two people were also subject to weekly blood sugar checks. A staff member told us this was something that had always been done yet was not prescribed by healthcare professionals.
- One person had their cigarette usage monitored and managed by staff although they had expressed they were not happy with this arrangement. We saw staff had recorded 'concerns' about two occasions that the person wanted to smoke outside of these planned times. This did not assure us that the person had choice and control over their care as far as possible although the provider told us they felt the person's reduced smoking had a positive impact on the person's life.

Meeting people's communication needs; End of life care and support

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.

- This standard was not fully met. Staff often described people's communication needs in terms of how it affected staff, for example, how well staff could understand people. This lacked awareness of the requirements of AIS and ensuring people's needs were met and that people were given information

presented in a way they could understand.
● People's communication needs had not been adequately assessed to identify any support they needed in line with AIS. A staff member told us, "[Person's] fine," when we asked how the person was supported with their sensory impairment.
● No one needed end of life care and support at the time of the inspection. One person's wishes were being discussed, in case they needed end of life support in the future. However, another person's care plan gave the generic instruction to carry out the person's wishes without providing the detail of what those wishes were. This did not ensure the person's expressed wishes were recorded and could be known to those involved in their care.

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.
● People had had some input in their care plans, for example, to gather information about people's lives and histories before joining the home.
● We saw, and one person told us they could get up when they wanted to.

Improving care quality in response to complaints or concerns
● People were reminded how to complain during residents' meetings. One person told us they could complain if they needed to by speaking with staff, but they were not familiar with a formal complaints process. No formal complaints had been submitted. This meant some potential areas of improvement may not have been identified through the complaints process.

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, "It's really nice here, I play dominoes, cards, there are lots of activities… It is a happy place, I go to day centre twice a week." Staff told us they encouraged activities such as drawing and baking.
● Transport was arranged for people to go out, for example, to a day centre regularly.

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; 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 identified widespread and significant shortfalls in the safety of the service and how people's needs were managed. Inadequate governance systems meant learning was not taken from incidents and concerns to ensure the quality and safety of the service.
- Numerous risks were not adequately assessed which placed people at ongoing risk of harm and poor care and meant staff did not have shared and informed understanding of how to safely support people.
- Poor risk management compromised one person's health and dignity and placed staff at risk, but this had not been identified as a concern. Another person had a known risk of making allegations of abuse. No systems had been developed to help protect this person and staff.
- The provider's ineffective systems meant allegations of abuse and other potential safeguarding matters were overlooked. This placed people at ongoing risk of harm and abuse. Despite our urgent prompts, the provider failed to immediately rectify this and failed to show regard for the requirements of the duty of candour. Regarding allegations of abuse against staff, the provider told us, "It did not happen… I honestly don't know what can be done about this." We continued to escalate our concerns to the local authority.

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

- Leaders lacked understanding of the principles of good quality assurance and there were not clear governance systems to assess, monitor and improve the quality and safety of the service. The provider failed to adequately address and respond to our concerns during inspection and enforcement processes.
- Systems failed to ensure the safety of the premises at all times, for example through adequate health and safety checks and to learn from safety incidents such as fire alarm faults and an occasion where it was suspected a member of the public had accessed the home.
- Systems failed to identify and address improvements required to care planning processes and medicines management.
- Our discussions with staff and sample of records found the provider had failed to notify us of specific incidents and events including safeguarding matters as required.

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.

Working in partnership with others

● We shared our significant concerns about this provider with the local authorities who also engaged with the provider during our inspection and enforcement processes.

● The local authority had recently carried out health and safety checks and prompted the provider to carry out improvements. We identified further concerns that had not been addressed.

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 said they felt supported and would recommend the service to loved ones.

● People had completed a survey about the home, but one person told us they had not heard feedback from this. The person said they did not feel anything could be improved and they were happy with the service.

● The provider displayed their previous inspection ratings as required.

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 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:

See NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 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:

See NOP

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 the management of medicines.

The enforcement action we took:

See NOD

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 the management of medicines.

The enforcement action we took:

See NOP

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:

See NOD

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:

See NOP

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:

See NOD

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:

See NOP

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 including to ensure persons employed received appropriate support and training.

The enforcement action we took:

See NOD

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 including to ensure persons employed received appropriate support and training.

The enforcement action we took:

See NOP