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 accommodation and personal care for up to 29 older people, some of whom may live with a mental health condition or dementia. At the time of our inspection 23 people lived at the service.

People's experience of using this service
Risks to people's health, safety and welfare were not always identified and managed. Lessons were not learned when things went wrong. Medicines were not managed safely.

There were gaps in the skills and knowledge of staff in relation to fire evacuation procedures and supporting people with complex needs and behaviours that may challenge.

People did not always receive person-centred care and care records did not fully reflect their needs. There was a lack of meaningful activities for people.

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.

Areas of the environment were poorly maintained. Some improvement works had been completed recently and other work underway, following guidance from the community infection prevention and control nurse. Appropriate standards of hygiene had not been maintained in all areas.

Staff were recruited safely. Feedback from staff was mixed about having sufficient numbers of staff on all shifts to meet people's needs. We have made a recommendation about reviewing people's dependency needs effectively and the staffing levels.

People and relatives said they liked the staff and described them as kind and caring. However, there were times when some people's dignity was compromised.

People's nutritional needs were met. Although staff worked closely with a range of health and social care professionals, there had been delays in making referrals for assessments when some people's needs changed.

The service was not well-led and there continued to be a lack of effective governance and oversight by the provider and manager. The provider's quality assurance systems were not effective in identifying and addressing issues. The provider had not always notified CQC when people had deprivation of liberty safeguards authorised by the placing authority. The service has a history of not sustaining improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 14 September 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations and significant concerns remained.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about infection control, the premises and management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led. However, we identified other concerns during our inspection and therefore a decision was made for us to inspect all five key questions.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

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 have identified breaches in relation to person-centred care, safe care, consent, dignity and respect, the environment, staff training, governance and notifications.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hadley Place Residential Home on our website at www.cqc.org.uk.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not 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
This inspection was carried out by two inspectors.

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.

There was no manager registered with CQC at the time of our inspection visit. The previous registered manager had left the service in February 2018. The manager had applied for registration and had not been successful. It is a legal requirement to have a registered manager. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced from the car park of the service on the first day of inspection. We did this to discuss the safety of people, staff and inspectors with reference to Covid-19. We told the manager we would

be returning on the second day.

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, Healthwatch and professionals who work with the service. 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 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 used the service and one relative about their experience of the care provided. We spoke with eleven members of staff including; the manager, the assistant manager, the administrator, three care staff, two senior care assistants, two housekeepers and the cook.

We reviewed multiple people's care files, daily records of care and medication records. We also reviewed one staff personnel file. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We conducted a walk around of the service and spent time observing staffs' interactions with people as well as staffs' infection prevention and control practice.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at surveys and dependency records. We spoke with a professional and three relatives.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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.

- Risks to people were not properly assessed or managed safely. Risk assessments were not always updated following incidents or a change in people's needs.
- There was a lack of detailed behaviour management support plans to provide staff with information to identify potential triggers or how they should support or redirect people in different situations. For example, declining personal care, verbal aggression, violent and disinhibited behaviours.
- Not all staff had completed fire drills or evacuation training. This meant they may not know how to support people safely in an emergency.
- Shortfalls had been highlighted to the provider following the last inspection; they had not taken action to address all the issues raised and the quality and safety of the service had further deteriorated.
- The provider had not acted accordingly to learn lessons when things had gone wrong. Accommodation was over four floors with stair access to the third floor. Despite a person having recently sustained a fall on the stairs, there had been no general risk assessment completed on the safe use of the stairs nor any individual risk assessments completed on people's ability to use the stairs safely.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm as a result of the issues we found. This was a continued breach of regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People had not always received their medicines as prescribed. One person had not received their pain relief medicine over a long period of time. Two people had not received their topical medicines for acute problems with their skin. Staff had not always referred refused medication back to the prescriber to enable them to review treatment options.
- Some people were prescribed medicines to be taken when required (PRN) for distressed or anxious behaviour. The medication administration records (MARs) for four people showed they were administered

PRN Lorazepam on the same medicines round on 9 April 2021. When checked, their daily notes did not reflect they had required this medicine recently, exhibited any distressed behaviours at the time or the reason they were given. This indicated these people were administered psychotropic medicine which was not needed.

● The accuracy of recording and use of PRN protocols was inconsistent. Protocols were in place for some regularly prescribed medicines and some protocols needed more information to guide staff. For example, the techniques used to distract people before the last resort of medication and the dosage of medication to be administered.

● Shortfalls were also found in aspects of medicines management relating to the storage separation of internal and external medicines, accurate use of codes, stock management and rotation, and a lack of oversight in the use of homely remedies. One person had their own stock of eye wash and drops, pain relief, emollient creams and inhalers, which staff had no oversight of or had risk managed.

Not ensuring people received their medicines as prescribed placed 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.

Preventing and controlling infection

● Not all areas of the service were clean. For example, some flooring needed cleaning and limescale had built up on taps. Commodes in two people's rooms and a shower chair were soiled and unhygienic.

● The medicines trolley was dirty. The interior and exterior of the trolley required cleaning. Cups for water had water marks and needed cleaning.

● The cleaning schedules did not detail each task, so it was difficult to check what cleaning had been completed. Equipment was not included in the cleaning schedule.

● There was no paper towel provision at the hand basins in three people's rooms. This did not promote effective hand hygiene practices.

Not ensuring good infection prevention and control systems placed people at risk of harm. This was a breach or regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● COVID-19 guidance had, in the main, been put into practice, under the direction of the community infection prevention and control nurse.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found systems were not in place to prevent and protect people from abuse and improper treatment. 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Some people who met the criteria for Deprivation of Liberty Safeguards (DoLS) did not have current authorisations in place. We saw five people met the criteria for DoLS but had not had a capacity assessment or application for DoLS completed, this was confirmed by the local authority.

Failure to lawfully deprive people of their liberty was a continued breach of regulation 13 (Safeguarding

service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received training in safeguarding adults and were clear about the action to take if they witnessed abuse or poor practice.
● The manager used local safeguarding procedures appropriately.

Staffing and recruitment
● There were mixed comments from the staff team regarding whether there was enough of them to give people the care and support they needed, especially when people were displaying distressed and anxious behaviours.
● The provider used a dependency tool to calculate the staffing hours required; the tool did not accurately reflect the needs of people living with dementia or a mental health disorder.
● Staff were experienced with a kind and friendly approach.
● The provider had a safe system of staff recruitment. Employment checks were completed before staff started work in the service.

We recommend the provider reviews how people's dependency levels are assessed to accurately inform the staffing numbers and deployment on all shifts.

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

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 service was not following the principles of the MCA. There was a lack of records to show mental capacity assessments and best interest meeting records had been completed for some people who lacked capacity to consent to their care.
- Restrictions were placed upon people with no evidence to support their consent being sought. For example, the use of bedrails and access to cigarettes and lighters. People's capacity to consent, or to make these decisions was not always completed. Decisions for these restrictions had not been discussed and recorded as in their best interest and as the least restrictive option for people.
- For those people who lacked capacity there were no records to show consent had been sought for their COVID-19 tests and vaccinations.

Failure to ensure consent to care in line with the law was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
- The environment had not been properly maintained. Relatives described the home as, 'run down', 'dated' and 'tired.'
- Items of furniture and equipment were worn, broken and needing repair or replacement.
- Varnish had worn off shelving and seating revealing bare wood, which was hard to clean.

● The flooring in people's rooms, the conservatory, dining room, corridors and stairs was damaged and worn.

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

● Improvements had been made to the staff changing room and medicines room following guidance from the community infection prevention and control nurse. Work was underway to improve the laundry in relation to the sluice facility.

Staff support: induction, training, skills and experience
● Staff had not always received the training and development they required to carry out their roles.
● Some people living with complex mental health needs and dementia displayed behaviours that challenged themselves and others. Staff had not completed training in positive behaviour support and told us they did not always have the experience or confidence they needed to manage and reduce these behaviours effectively.
● Not all staff had completed fire drills or evacuation training to ensure they understood what to do in an emergency. Staff were directed to use 'progressive horizontal evacuation procedures,' but told us they were not sure what this meant.
● Only 10 staff had completed essential training in donning and doffing of personal protective equipment (PPE). There had been delays in arranging this training for the remainder of the staff.

The above evidence shows a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the pandemic affecting the frequency of staff supervision meetings, staff felt well supported by the management team. New appraisal and supervision programmes had been put in place

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
● Systems were not in place to ensure people's needs were always assessed and their preferences fully understood. This meant people were at risk of receiving inappropriate care and support.
● Best practice tools had not been used to assess and monitor people's needs. For example, those at risk of poor food and fluid intake, pressure damage and choking.
● Staff did not always seek support from health care services to ensure effective and timely assessment. For example, one person had experienced a choking incident and although staff had provided emergency treatment to successfully dislodge the food item, there had been a delay in referring the person to the speech and language therapist (SaLT) for assessment. There had been delays in making referrals to the mental health and continence teams for other people.
● People did not always have hospital passports or information that could be quickly passed onto emergency services or healthcare professionals in the event of an emergency. This meant people were at risk of their medical needs not being met.

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

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

● People were provided with a variety of meals and refreshments throughout the day. The cook consulted with people about new menu choices.
● People told us they liked the meals and they had enough to eat. One person told us, "The cook is good, she makes us nice meals." A relative told us, "The meals are all home cooked, lovely food. Staff have got [name] eating again, they have always had a poor appetite. If they decline anything, staff will offer them choices and tempt them with something."
● People's weight was monitored. Staff were using both imperial and metric weight systems inconsistently, which was confusing, and we mentioned this to the manager to address.

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 comprehensive 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.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect, and their independence was not always promoted.
- The continence support for two people was poor and this impacted significantly on their dignity and independence. Both persons were regularly doubly incontinent in their rooms; effective support for them to consistently use the toilet facility or continence aids was not in place. There was an overpowering odour of stale urine in one person's room and surrounding area during the inspection.
- Communal products such as shower gel and shampoo were purchased by the provider and stored in a cupboard in the shower room. This is institutional practice and people should have their own supply of toiletries for their own personal use and of their own preference.

The failure to promote dignity and respect was a 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; Supporting people to express their views and be involved in making decisions about their care
- Due to the concerns identified during this inspection, we could not be assured that people received a high quality, compassionate and caring service. We have taken these concerns into account when rating this key question.
- People were not always well-supported with regards to their specific mental health needs and risks to their health and safety. This was not respectful of their equality and diversity.
- Processes were not always followed correctly to ensure people's rights were upheld and their capacity to make their own decisions considered and supported.
- We observed some positive interactions between staff and people who used the service. People told us they were happy and enjoyed living at the service. One person told us, "The staff have all been very caring and kind to me. In recent months I have struggled with my anxiety and felt very low, the staff have helped me through this."
- Many relatives acknowledged that they had been unable to spend any significant amount of time in the service over the past year due to the pandemic. Despite this, most told us they felt confident their family member was well cared for. One relative was concerned their family members clothing wasn't always clean when they saw them, but on recent visits they had been well presented and their hair done nicely. Comments from other relatives included, "The staff are always kind and patient. [Name of relative] can be complex at times, but staff understand them and what works with them. They always make me welcome"

and "It has a lovely family atmosphere here and the staff are all very caring and kind."

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 comprehensive 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; 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

- People's needs were not fully assessed, and risk assessments lacked important details, which impacted on the care plans developed from them and meant staff had limited care directions.
- Care records did not reflect people's care and support required. They were not evaluated and updated effectively to ensure people's needs were met safely. For example, one person had developed a serious skin condition which necessitated multiple visits from the GP and community nurse. The person's care records did not include information to direct staff on the change in their care needs in relation to personal care, applying creams, pain relief, elevating swollen limbs and discouragement from itching. A record on 18 March 2021, in the handover book, directed staff to provide daily showers due to further skin blistering. The person's shower chart showed they had only had five showers since that date.
- Care staff told us one of their colleagues was fully responsible for all the writing, evaluating and updating of each person's care plans and risk assessments. They felt they should have more involvement.
- People's end of life needs were not planned, which meant people's preferences and choice may not be known to staff. Two people were receiving end of life care support. One person's relative praised the staff for their kind and compassionate approach and were pleased with the standard of care provided.
- There was limited social stimulation for people in order to prevent boredom and isolation.
- There was no designated activity coordinator, structured programme of activities or records available to show what recreation had been provided. The activities seen on two days of inspection were watching television, listening to music, one person completed some colouring and another person was seen looking at a newspaper. There was little time and opportunity for staff to support people to participate in meaningful activities or to sit and chat with them.

The lack of assessing and planning care and support meant people's needs were not 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.

- We are mindful of the impact of the COVID-19 pandemic on the ability for people to go out into the community or to socialise indoors with visitors. Visits indoors were now being arranged.
- Feedback from relatives about communication during the pandemic was mixed. One relative said, "I took a scrap book of family photos to the service at the start of lockdown for [name of relative] to look at. One of the carers was so kind, they filmed [name of relative] opening it and looking through it, but that has been the only contact from them [staff] during lockdown." Another relative told us, "During lockdown they sent cards

and photo's which was lovely as [Name of relative] was admitted just before lockdown started."

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 communication needs were considered as part of their care plans.
- Staff used picture cards, sign language and an 'app' on their mobile phones to support effective communication with one person, whose understanding of English was limited. Staff also contacted a translator and the person's family to assist when necessary.

Improving care quality in response to complaints or concerns

- A complaints policy and procedure was in place. We asked the manager for the complaints log and they confirmed they had not received any complaints.
- Relatives knew how to make a complaint and told us the manager was approachable and dealt with issues appropriately.

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 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 provider had failed to have up to date records and have robust systems in place to identify concerns and act on these. This was a continued 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.

- At the inspections in July 2018 and October 2019 the provider had breached this regulation. We issued a requirement notice asking the provider to make improvements in this area. At the inspection in July 2020, the provider remained in breach of this regulation and we issued a warning notice in order to drive improvement at the service. We found there had been insufficient improvements in quality monitoring, records management and risks remained.
- The manager was not registered with the Care Quality Commission (CQC). The previous registered manager left the service in February 2018. The provider appointed a new manager, who had been unsuccessful with their application to register.
- The provider's quality assurance systems were not robust. There was ineffective governance and poor oversight at manager and provider level which had failed to fully identify shortfalls in the service putting people at risk of harm.
- Auditing systems were not effective. Systems and processes did not drive forward improvement. Timely action had not been taken to address known issues. Nine breaches of regulation were identified.
- An effective system to learn from accidents and incidents and prevent any reoccurrence and improve people's care was not in place.

The lack of consistent and effective leadership and robust quality assurance meant people were at risk of receiving poor quality care. This 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 the 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.

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

● The provider had again failed to notify the CQC of all notifiable incidents that happened in the service. CQC had not been informed when people had deprivation of liberty safeguards authorised by the placing authority.

This was a breach of Regulation 18 (2) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of the inspection process in relation to this matter.

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

● The provider did not have robust systems in place to ensure high-quality, person-centred care was being provided.

● Staff we spoke with felt the manager was approachable and supportive. The last staff meeting was in September 2020 and during lockdown the manager had written to staff to inform them of changes or improvements needed.

● People told us they were happy at the service; they were listened to and staff looked after them well. They had completed a satisfaction survey in March 2021 and the results were all positive. Most relatives we spoke with had not been asked for feedback about the service.

●The staff team had developed links and working relationships with a variety of professionals within the local community such as GP's, the local district nurses and frailty team.

● Despite the support and input of health and social care organisations to improve people's experiences and the quality of service provided, progress to make the improvements needed was inconsistent and slow.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to notify CQC when people had deprivation of liberty safeguards authorised by the placing authority.

The enforcement action we took:

We issued a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure all service user's needs were thoroughly assessed and appropriately planned for.

The enforcement action we took:

We issued a notice of proposal 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 The registered provider had failed to ensure service user's privacy and dignity was maintained.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not worked within the Mental Capacity Act 2005, when service users lacked the capacity to make their own decisions.

The enforcement action we took:

We issued a notice of proposal to cancel the registered 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 registered provider had failed to ensure there was a safe system of medication management to ensure people received their medicines as prescribed. The registered provider had failed to properly assess risk and take steps to mitigate the risk of accidents and incidents occurring. The registered provider had failed to ensure there were good systems in place to prevent the spread of infections.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

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 registered provider had failed to notify CQC when people had deprivation of liberty safeguards authorised by the placing authority.

The enforcement action we took:

We issued a notice of proposal to cancel the registered 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 registered provider had not ensured the premises were well-maintained.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure consistent and effective leadership and failed to embed robust quality assurance systems and operate effectively the systems for maintaining accurate records.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to provide staff with appropriate training and professional development as necessary to enable staff to carry out the duties they are employed to perform.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.