Optima Care Limited

Optima Care Limited - 37 Spenser Road

Inspection report

37 Spenser Road
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Optima Care Limited - 37 Spenser Road is a 'care home' providing personal care for up to 13 people with a with a learning disability and physical disabilities. At the time of our inspection 10 people were living at the service.

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

People were not protected against risks associated with their care. The environment and equipment were not always clean or properly maintained. These concerns were raised at the last inspection but had not been addressed. Staff were not always raising concerns around about neglect and abuse. The local authority were not always being informed when safeguarding incidents occurred.

People's medicines were not always being managed in a safe way. Accidents and incidents were not always recorded, and not enough action was taken to reduce further risks to people.

There was an insufficient number of staff deployed to ensure that people received their care when needed. The registered manager and provider did not have appropriate systems in place to review the dependencies of people to ensure sufficient staff were on duty.

The leadership at the service was not robust and there was a lack of auditing to review the quality of care provided. Staff did not always feel supported or valued. Notifications were not always being sent to the CQC when it was appropriate to do so.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People were not always supported with their independence. Staff did not always have an understanding of the support and care people needed to enable them to have a fulfilled life. The was a closed culture at the service where practices were at time institutionalised.

Right support:
• Model of care and setting did not maximise people's choice, control and Independence

Right care:
• Care was not person-centred and did not promotes people's dignity, privacy and human rights

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives
Following this inspection, we worked closely with the local authority (Kent County Council) and the Clinical Commissioning Group (CCG) to ensure people were safeguarded from ongoing harm. Alternative placements are being sought for some people.

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 22 October 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 we found sufficient improvements had not been made and the provider remained in breach of regulations.

This service has been in Special Measures since 22 October 2020. During this inspection the provider was unable to demonstrate that improvements had been made. The service is rated as inadequate in the key questions Safe and Well Led. Therefore, this service remains in Special Measures

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We received concerns in relation to people not being safeguarded from the risk of abuse. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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.

We have found evidence that the provider needs to make improvements. Please see the Safe, and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Optima Care Limited - 37 Spenser Road on our website at www.cqc.org.uk.

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 people not being protected from the risk of neglect and abuse, risks related to the care being provided to people, the lack of suitably qualified staff and the lack of robust provider and management oversight at this inspection.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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.

The overall rating for this service is 'Inadequate' and the service remains 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.

For requirement actions of enforcement which we are able to publish at the time of the report being published. Please see the action we have told the provider to take 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?

Inadequate

The service was not safe.

Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below

Optima Care Limited - 37 Spenser Road

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
Our inspection was completed by three inspectors.

Service and service type
Optima Care Limited - 37 Spenser Road 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 had a manager registered with the Care Quality Commission. This means that they 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 unannounced.

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. 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 two people who used the service about their experience of the care provided. We spoke with six members of staff including the registered manager and care staff.

We reviewed a range of records. This included six people's care records and multiple medication records. We reviewed a variety of records relating to the management of the service, agency staff profiles and policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from one professional who visited the service and spoke with three relatives of people at 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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection of the service, we found the provider had not protected people from the risk of abuse. 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 not been made at this inspection and the provider was still in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse

- At the previous inspection we identified that the local safeguarding authority were not always being notified of safeguarding incidents. We found at this inspection that this had not improved. The local authority advised us prior to the inspection that there had been incidents of abuse between people living at the service that had not been reported to them.
- People told us they felt safe at the service. However, despite these comments, we found people were not safe and had been harmed. One staff member told us they had witnessed another staff member restraining a person but did not consider this to be a safeguarding concern. The staff member told us, "(The person) fought back as he has never been restrained that way." We saw minutes that the member of staff had been present at a staff meeting prior to this incident in February 2021 there they were told that no restraint should be used on people at the service. Other staff told us they were not trained to undertake any physical restraint with people. One told us, "We've had behavioural training and I know we can't do restraining." The registered manager had been aware of this incident but had not taken steps to report this to the local authority. They said, "I do believe that (person) had a bit of an issue, just that he wasn't very happy and went for a member of staff."
- Restrictions were being placed on people without their individual wishes being considered. For example, the kitchen and bathroom door remained locked when there were no staff present. This meant people were not able to access these rooms without asking a member of staff first. We asked a member of staff why this restriction had been in place and they told us they believed it was due to a safety concern but that it had, "Always been that way."
- People were not being protected from the risk of abuse. Staff we spoke with were not always familiar with what constituted abuse or what they needed to do if they suspected someone was being abused. One member of staff told us, when asked, if one person living at the service hitting another would constitute abuse and they told us it didn't. They told us, "No one is abusive to anyone here." However, we identified a number of incidents when there had been physical abuse from one person to another.
- We identified instances where people had not had their prescribed medicine on two occasions. The local authority had not been informed of this and it was not investigated by staff at the service as potential neglect. We identified other safeguarding incidents on the inspection that the local authority have confirmed they were not aware of. Some of these incidents had also not been investigated by the registered

manager in order to keep people safe from the risk of abuse or ill treatment.

Failure to ensure people were protected from the risk of abuse was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of the service, we found the provider had failed to ensure risks to people were appropriately managed, and we found people were still at risk of unsafe care. 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 not been made at this inspection and the provider still in breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;
● At the previous inspection we identified risks assessments relating to people with epilepsy were not in place. At this inspection we found these risk assessments had been put in place however they were not person centred. For example, one person who experienced frequent seizures had a risk assessment that was generic and did not reflect the signs staff needed to look out for leading up to the person having a seizure. This posed a risk that these signs would be missed, especially by staff working at the service know did not know the person.
● Risks to people had not always been considered and there was a lack of detailed actions in place to mitigate them. We saw from an incident report that one person had fallen in January 2021 and required medical attention. There was no falls risk assessment undertaken as a result of this fall or any preventative measures recorded to guide staff. Another person was at risk of having seizures whilst in the bath. There had been incidents where this had occurred. However, the person's risk assessment had not been updated to guide staff about what actions they needed to take should this occur.
● Where other risks had been identified, staff were not always following the appropriate guidance. One person's care plan stated the person needed to have paracetamol 30 minutes before their personal care each day. This was recommended by the person's occupational therapist to relieve pain and discomfort. However, we saw from personal care notes that the person was regularly given their care by night staff before they went off duty each morning. The paracetamol was not given to the person until after they had their personal care.
● Where staff were required to record on a pain chart for a person this was not always being completed. For example, one person required the pain chart to be completed each time they had personal care. On the day of the inspection we were aware of the person having their personal care on at least two occasions. The pain chart had not been completed on both occasions.
● There were people at the service who had behaviours that put themselves and others at risk. However staff were not able to demonstrate their understanding of the person's triggers or early warning signs to reduce the risk of the person's behaviour escalating. Despite there being detailed guidance in place this was not being followed by staff to be able to support the person safely and consistently. Staff had not been trained in positive behaviour support which put the person at risk of harm of inappropriate use of restraint and physical intervention. This also placed other people at risk of harm from the lack of safe management of the person's behaviour.
● Staff told us they had not read the risk assessments in peoples care plans. One told us, "I have never read people's risk assessments." When asked how she would find out about any changes to people's care, they said, "Day to day you would find out if people's needs have changed."
● The environment continued to pose a risk to people. Since the last inspection the provider had ensured that equipment used for moving and handling people had been safety checked. However, we found chemicals in the laundry room and in a cupboard in the main house were accessible to people as the doors had been left unlocked. The shed door in the garden (which people were able to access) had been left open

meaning tools and equipment were within reach of people which posed a risk.
● At the previous inspection we identified there was no formal analysis of incidents to identify and learn from patterns and trends. This had still not been sufficiently addressed at this inspection. Staff were not always recording incidents in the appropriate way; some were only recording incidents on daily notes or the staff communication book. The provider sent us an action plan after the last inspection that stated, "All incident reports will be reviewed and signed by management. Monthly analysis will be completed and include incident by person and type, as well as any trends, patterns, outcomes and learning." We found this was not taking place.
● It was recorded in the staff communication book in December 2020 that one person was, "Choking on her pillow during the night as her breathing was forceful until morning." The registered manager told us they had not been made aware of this and that they never read the communication book. This meant that the provider or registered manager could not demonstrate how they were assured that appropriate action was being taken to mitigate risks to people and to look for themes and trends.

Using medicines safely
● The management of medicines was not always undertaken in a safe way. There were people at the service that required time specific medicines (medicines that need to be given at the same time each day). The Medicine Administration Record (MAR) had prepopulated times written on them. The registered manager told us that morning medicines were given to people from 07.00 onwards. The MARs stated that each person was given their medicine at 08.00 and was not always a true reflection of when the medicine was actually given.
● There were not always PRN (as and when medicines) guidance in place for each person which meant that staff may not always give medicines when needed. There were creams and a person's prescribed thickener that did not have the opening date on them to ensure that they were still safe to apply. This was despite staff being reminded to do this. There was a note in the staff communication book in February 2020 that stated, "So many creams are having to be returned as staff members are not following correct procedures and documenting date of opening. Please ensure this is completed."
● The MAR detailed what prescribed creams were needed for and there was a body map to show where to administer these. However, there were frequent code 'F' used on the MAR with a note on the back stating the cream had not been administered with no information on reason it was not given. A member of staff told us the night staff may have administered the creams if there was a code 'F' however there was no way of knowing if this had actually taken place as the night staff were also not recording whether this had been applied.
● Staff had received training and were competency assessed to administer medicines. However, we saw on an incident report that one person was not given their medicine on two occasions. The action recorded for this was the member of staff was to have a further competency assessment. However, the evidence provided to us by the registered manager demonstrated this had not taken place.

The failure to always manage risks associated with people's care in a safe way was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were aspects of the risks around care that were appropriately managed. We saw that a risk had been identified around the use of using paraffin creams on people's skin. There were management plans in place that stated that the person should avoid being around a naked flame and that their clothes needed to be regularly laundered.
● There were Personal Evacuation Plans (PEEPS) in place for people with details around how they needed to be supported in the event of an emergency. There was a 'Business continuity plan' that detailed what staff

needed to do in the event of an emergency such as a flood or a fire. We saw that staff received fire safety training and that regular fire drills took place.

At our last inspection of the service, we found the provider had failed to ensure there were sufficient numbers of suitably qualified staff working at the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider still in breach of regulation 18.

Staffing and recruitment

● There were insufficient staff deployed to keep people safe from harm: staff did not have the right skills, training or competencies to support people safely or to meet their needs. This had a major impact on people's safety. At the previous inspection in August 2019 we identified that not all staff had received training in positive behaviour support (PBS) despite there being people with behaviours that could challenge others. At this inspection out of 17 staff 15 had still not received PBS training. In addition, three people were living with epilepsy and not all staff had received training in this. Although the service specialised in providing care to people living with autism not all staff had received training in autism. Ten staff had not received training in choking despite the registered manager telling us that six people were at risk of choking.

● In addition to staff not having the right training or skills, there were insufficient staff deployed to ensure people's needs were met in a safe way. This had a major impact on individual people's safety. One person's bedroom was situated in a separate 'annexe' to the main house. This building had a sensory room and lounge and the registered manager told us this was intended for use of the person. They told us a member of staff needed to remain in the annexe when the person was resting in their bed during the day. However, we found the person had been left on their own in the bedroom for nearly an hour in the afternoon whilst staff continued with other duties in the main part of the service. The person was unable to alert staff if they needed any support which put them at risk. Staff were encouraged to return to the main house when they had supported the person to their bed. A note in the staff communication book in February 2021 stated, "When personal care needs for (person) have been completed can you please ensure you remain at Spenser House (the main house) to support here."

● Another person had behaviours that challenged that put themselves and other people at risk. The registered manager told us, "We think his behaviour is escalating. I think he should be on a one to one." They said they had not implemented this as they did not believe the funding authority would fund this.

● Staff fed back that having additional duties on top of their care role impacted on people living at the service. One told us, "By the time you do personal care you then have to start on the laundry. We only have one tumble drier, so everything takes longer. I don't think there is enough staff. If we didn't have to do the laundry and cleaning, we could be doing something with them (people)." Another told us, "Cleaning and laundry takes time away from residents."

● When agency staff worked at the service, they were not always given an appropriate induction into the care that people needed. One member of staff told us they had not read any summary care plans for people and did not know their needs. They told us, "I would have a better understanding of who I am dealing with. I have not been told much else about anything." Another told they were only given information about people's needs from staff but said this was at times conflicting. They said, "Everyone says something different for example (person) with his meals, some say when his mouth is shut, he wants more but others say when his mouth is open, he wants more."

● Agency staff that had worked at the service for a long period of time did not have supervision or competency assessments in relation to their work performance. The registered manager told us this was not in the supervision policy and had not recognised this could help to ensure the longer standing agency staff were undertaking their role appropriately. Relatives fed back to us there was not always a consist staff

presence at the service. One told us, "The turnover of staff is so high and with agency they don't know the residents."
● The registered manager was not always familiar with which agency staff were on duty. On the day of the inspection the registered manager introduced us to a member of staff who they said was working their first day at the service. However, the member of staff confirmed they had already worked there for a full shift two days prior and had already met the registered manager. There were insufficient checks that agency staff had the skills and experience to support people with complex needs. One member of staff we spoke to told us they had not worked with people with a learning disability before. This was also confirmed by their agency profile.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found the provider had failed to ensure appropriate checks on staff had taken place before they started work. This was a breach of regulation 19 (Fit and Proper Persons Employed) 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 regulation 19.

● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks were carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The provider confirmed that people were not being admitted to the service. However, there were systems in place to do this in a safe way.

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 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.

At the previous inspection we found that there was a lack of leadership and systems and processes were not established and operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there had not been sufficient improvement made and the provider remained in breach of regulation 17.

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

- At the previous inspection we identified that the leadership, auditing and governance was not robust which meant that the quality of care was poor. At this inspection we found this had not improved. There was a lack of management and provider oversight. We continued to find shortfalls that had not been identified through the provider or registered managers audits.
- The registered manager told us the provider undertook regular audits to the service. We asked to see evidence of these audits however we were only sent an audit for July 2020 which was prior to the last inspection. We received no evidence of audits that had taken place to follow up on the actions the provider had needed to take to ensure the shortfalls had been met.
- There was no effective system in place to ensure staff were aware of their duties and their allocated jobs for the day. The registered manager showed us an allocation sheet that assigned roles to staff through the day. However, these allocations were not shared with staff. We asked a member of staff if they knew what role they had been allocated that day. They told us, "I wouldn't know." Another told us, "I am left feeling 'what do I do?' No one has followed up with me."
- The registered manager told us they wanted to improve the daily handover with staff. However, when we spoke with staff, they told us they often did not attend a handover when they came on duty or at the end of their shift. One member of staff said, "Handover didn't happen this morning, the other day staff did not turn up till after eight (am). I had to ask (a member of staff) what I needed to do." Handovers are important so that those staff going off and coming on duty communicate with each other about what has happened in the service in the previous shift, how people living there are doing, and what needs to be done during the next part of the day.
- We asked the registered manager how many handovers they had attended since starting at the service in September 2020. They said they had not been to any handovers as they had been too busy with other administrative duties. They also confirmed they spent the majority of their day in their office as they were busy with other duties. They said, "I think I have a massive workload; I find I can do a lot more at home." They told us if they worked downstairs, they would frequently be interrupted by people living at the service.

● Relatives fed back they were concerned about the leadership at the service. One told us, "If they (staff) are not given the right support at the top it doesn't filter down." Another told us, "The last few years they (managers) can come and go. We don't know who the manager is now."
● Staff fed back there needed to be increased management presence at the service. One member of staff said, "The manager comes down (from the office) when they need to, it doesn't help being upstairs. Maybe once in the middle of the day I see her." Another said, "The manager comes in, gets her tea and then goes upstairs. She knows nothing about the clients." A third told us, "Leadership could be better. Management should be on the floor more. How can you manage a home when you don't know people? She spends a lot of time in her office."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although surveys had taken place with people in August 2020, sufficient action had not been taken where concerns had been identified. For example, in the 'resident' survey comments from staff who supported people completing the survey included, "The survey did not allow to state whether someone strongly agreed or disagreed. The survey merely allowed for Yes/No responses and free commentary." The action for this was for the, "Manager to conduct a second survey involving as many participants as possible" and "Survey to be amended to show the range of response." We found this had not taken place.
● People were not being engaged in meaningful activities. The registered manager showed us an activity schedule that had been planned with people. However, these activities were not always taking place. For example, on the day of the inspection the schedule stated that 'Music and Movement' was the morning activity and a quiz was taking place in the afternoon. Neither of these activities took place. A member of staff told us there was no schedule of activities. They said, "We sort of go with the day."
● Staff told us they did not always feel supported or valued. Some staff that felt they had opportunities to progress within the service. One member of staff told us they had been given increased responsibilities. However, staff told us that during a 12 hour shift they were not allocated a break. One member of staff said, "We have to eat our meals and drinks with people. We never have breaks." Another told us, "There is no staffroom so we don't take breaks, we are told can eat when we want. No one is allocated a break."
● Although staff meetings were taking place these were not always being used to address staff concerns and feedback. For example, in a meeting in January 2021 staff raised concerns about not being able to take breaks. The notes states that the registered manager took the concern on board and would establish how the other providers services managed this. However, on the day of the inspection the registered manager told us they still needed to look into this.
● The last survey with staff was undertaken in August 2020. Comments from this survey included that there was a lack of communication, lack of detailed handover and staff not always feeling supported and valued. We found that this had not been sufficiently addressed and staff continued to have the same concerns.
● There was a closed culture at the service where staff were not sharing their concerns with management. For example, the safeguarding policy stated that, 'Unauthorised' restraint on people would constitute abuse". It stated that the provider was, "Fostering an open and trusting communication structure so that staff, service users and others feel able to discuss their concerns with someone authorised to act." However, we found instances of alleged abuse that were not reported or acted upon to ensure people's safety.

Working in partnership with others; 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 previous inspection we identified that the provider had not always been open and transparent with external stakeholders and agencies. This continued to be a concern and we found several instances of safeguarding that had not been reported to the local authority or the CQC.

● The registered manager and staff worked with other external organisations in relation to people's care. For example, we saw that the Speech and Language Therapist had been consulted in relation to people's care. Guidance from them had been placed in people's care plans however staff confirmed to us they were not reading people's care plans. The provider and registered manager could not be confident that staff would follow the appropriate guidance.

Failure to carry out robust quality checks and a lack of leadership at the service is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found the provider had not been submitting notifications to the CQC where required. The was a breach of regulation 18 of the (Registration) Regulations 2009. At this inspection there had not been sufficient improvement made and the provider remained in breach of regulation 18.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. At the last inspection we identified that incidents were not being reported appropriately to the CQC. This had not improved.
● On the providers action plan following the last inspection, they stated, "All safeguarding incidents will be reported to the CQC." However, we found this was not taking place. During the inspection we identified instances of safeguarding concerns that should have been notified to the CQC, but no steps had been taken to do this by the provider or registered manager. We also identified an incident from November 2020 when a person had sustained a fracture to their ankle. This had not been reported to the CQC as required.

This was a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.