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Grove Villa Care

Inspection report

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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

We undertook an unannounced focused inspection of Grove Villa Care on 6 and 7 November 2018. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 23 and 24 July 2018 had been made. The team inspected the service against two of the five questions we ask about services: is the service well led, is the service safe. This is because the service was not meeting some legal requirements at our last inspection and we had received concerns about people's safety from the local authority safeguarding team and whistle-blowers.

No significant improvements were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

At the last inspection we found serious concerns regarding the provider's oversight and overall management of the service continued. Breaches of six regulations continued and there were new breaches of four regulations of the Health and Social Care Act 2008. There was also a continued breach of the Care Quality Commission (Registration) Regulations 2009. The service was rated Inadequate and remained in special measures.

Following our last inspection, the provider sent us improvement action plan to show what they would do and by when to address the breaches. The improvement action plan was not adequate. Despite a request for a more robust plan, the information we received from the provider did not assure us that they understood our concerns and had a plan in operation to address them promptly.

At this inspection we checked to see if concerns in relation to protecting people from abuse, unsatisfactory medicines management, unsafe care, poor staff recruitment and deployment and infection control risks had been addressed. We also checked to see if the management and leadership of the service had improved and the views people and others involved in their care had been used to improve the service. We found the provider had made no significant improvements and people continued to be at risk at the service.

Grove Villa Care 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. Grove Villa Care accommodates 16 people in one adapted building. There were 15 people using the service at the time of our inspection. People using the service had a range of physical and learning disabilities. Some people were living with autism and some required support with behaviours that challenged.

The care service had not been developed and designed in line with the values that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People were not supported to live an ordinary life, like any citizen.

There was no registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not have oversight of the service. Checks and audits completed had not identified the shortfalls we found during our inspection. Many areas of the service had not been checked. The views of people, their relatives, staff and community professionals were not obtained to improve the service.

Staff had not been deployed to provide people with the care they needed. Some people remained isolated. Staff had not been recruited safely and checks had not been completed to make sure they had the skills knowledge and experience they needed to fulfil their role.

Risks had not been assessed and action had not been taken to keep people safe and well when their needs changed, including the risk of falling. Staff did not always follow guidance when people had seizures. People were not protected by safe and effective medicines management processes. Medicines were not always stored safely. One medicine was out of stock and others had not been administered as prescribed.

People were not fully protected from the risk of fire and staff did not know how to support people to remain safe in an emergency.

Incidents of potential abuse by people to other people had not been recognised as potential safeguarding incidents and reported to the local authority safeguarding team so they could be investigated.

Records in respect of each person were not accurate and complete. Accidents and incidents analysis was incorrect as it was based on flawed information. Areas of the service and equipment were not clean.

The provider had not informed CQC about all the significant events that had happened at the service, so we could check that appropriate action had been taken.
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service continued not to be safe.

Staff had not identified and reported safeguarding concerns.

People were not always protected from risks.

Staff were not recruited safely.

Staff had not been deployed to meet people's needs.

People's medicines were not managed safely.

People were not always protected from the risk of infection.

Is the service well-led?

Inadequate

The service continued not to be well-led.

The provider lacked oversight the service.

We had not been informed of important events that happened at the service.

Checks and audits had not identified shortfalls.

Significant improvements had not been made to the service.

People, their relatives and others had not been asked for their views on the service.

Grove Villa Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by whistleblowing and safeguarding concerns we received both anonymously and from the local authority safeguarding team. Information shared with the Care Quality Commission about a lack of leadership at the service indicated potential concerns about the management of risks and medicines and staff's skills and deployment. This inspection examined those risks.

This inspection took place on 6 and 7 November 2018 and was unannounced. The inspection team consisted of two inspectors and a medicines inspector.

Before the inspection we reviewed information, we held about the service. We used information the provider sent us in an improvement plan. We also reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury. We contacted the local authority safeguarding, care management and commissioning team who had recent involvement with the service for their views and received responses from all of them.

We did not ask the provider to send us in the Provider Information Return (PIR) as we inspected at short notice. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with three people and seven staff. We looked at care records and associated risk assessments for three people. We looked at management records including staff recruitment, training and support records and health and safety checks for the building. We observed the care and support people received. We looked at their medicines records for everyone and observed people receiving their medicines.

Some people were unable to tell us about their experience of care at the service. We used the Short

Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

Inadequate

Is the service safe?

Our findings

Before our inspection we received information from the local authority safeguarding team and care managers that people may be at risk at Grove Villa Care. We found that people were not safe.

At our inspection in July 2018 we found people were not protected from the risk of abuse and harm. At this inspection these risks continued. The provider and management team continued not to recognise safeguarding concerns and had not acted to protect people.

Incident records showed people had been assaulted on at least 10 occasions since our last inspection. One frail older person had been the victim of three assaults. The deputy manager told us all incidents where a person was assaulted were recorded and reviewed by them to decide what action should be taken. However, only four had been reviewed and no further action was taken to prevent similar incidents happening again. We discussed one incident with the deputy manager, they told us the assault should have been discussed with the local safeguarding team. On the first day of our inspection we asked the manager to audit records and notify the local authority safeguarding team of all incidents of assault. We discussed this with the local safeguarding team after our inspection. They had not been informed of all the assaults and we shared this information with them.

Incidents of possible abuse including assault had not always been recorded. On the first day of our inspection we observed two incidents. On one occasion we saw a person hit another person's hand with such force that they bent it backwards. The person looked shocked, rubbed their hand and folded their wrist forward to relieve the pain. We asked to see records of these incidents on the second day of our inspection. We were not shown these during our inspection and did not receive them following the inspection. We raised our concerns with the local authority safeguarding team.

The provider had failed to protect people from abuse. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that robust systems were not in place to safeguard people's money. At this inspection we found that action had been taken to improve the processes and people's money was managed safely.

People continued not to be protected from the risks of unsafe care. At our previous three inspections, risks relating to people's care and support had not been adequately assessed and guidance for staff did not contain the level of detail necessary to keep people safe.

At our last inspection we found that incidents of behaviour that challenged were not consistently recorded so they could be analysed to look for patterns and trends and ways of reducing them happening again. At this inspection the deputy manager told us that analysis was now completed. However, we found no analysis of each incident had been completed and the risks to people continued.

The deputy manager told us that 'normal' incidents of behaviour that challenged were recorded in general records and 'abnormal' behaviour or when an incident resulted in injury were recorded on an incident form. The general records did not provide enough detail to enable an analysis to be completed. For example, one record stated, 'Support due to challenging behaviour (25 mins)'. The manager told us they thought that staff had not been reporting incidents because they regarded it as "that's just [the person] being [the person]" and had not recognised incidents of behaviour that challenged.

We looked at the care records for three people with behaviours which challenged. Two people's risk assessments had been rewritten since our last inspection and required staff to complete 'ABC charts' when people showed behaviours that challenge. An ABC chart is used to record behaviour that challenges to help analyse what was happening before the behaviour (the antecedent) the behaviour itself and what happened after and how people responded (the consequences). The deputy manager told us that ABC charts were not used at the service as staff had not been trained to use them, this was despite the manager telling us they were a 'basic' requirement at the service.

Detailed guidance had not been provided to staff about how to support people when they had behaviours that challenge and staff did not follow an agreed strategy to support people in a consistent way. We asked staff how they supported one person when they had behaviours that challenge. One staff member told us that they chatted to the person and if they did not calm they took them to their bedroom. The were no guidelines in place for staff to follow about how to support the person safely to their bedroom, when to do this and how to support the person when they were in their room. Records showed that the person regularly had behaviours that challenged and staff took them to their bedroom on occasions.

Staff did not have the skills to support people with behaviours that challenged. Before our last inspection some staff had received training in 'managing challenging behaviour'. However, four of the six staff working with people during our inspection had not completed the training. The manager and deputy manager had also not completed the training. During our inspection we observed staff did not always respond to people's behaviours in a supportive way. A staff member responded, "OK, that's enough" in an angry way to one person.

There was a continued risk that people living with epilepsy would not receive the care and treatment they needed when they had a seizure. Guidelines were in place for one person and action was being taken to finalise interim arrangements. Staff told us the interim arrangements remained in place and emergency medicine should be administered if the person had a seizure which lasted more than five minutes. However, guidelines were not always followed. For example, staff called for an emergency ambulance rather than giving a person emergency medicine. The reason for this decision had not been recorded and the management team did not know why the medicine had not been given.

Staff did not have the skills to assess and manage risks when supporting people to transfer and reduce the risks of them falling. We observed one person sobbing and becoming very frustrated because they could not sit where they had done previously, because their needs change changed. Care had not been planned to reduce the risk of the person falling, other than to restrict them to their wheelchair. Alternative seating had not been considered. The person had fallen shortly before our inspection and staff had called an ambulance crew to support the person off the floor. Support had not been planned to assist the person if they fell again.

People continued not to be protected from the risks associated with fire. We shared our concerns with Kent Fire and Rescue Service, following our last inspection. They had required the provider to act to comply with the Regulatory Reform (Fire Safety) Order 2005. The deputy manager told us the provider managed fire safety and they did not know if the actions required by Kent Fire and Rescue Service and the provider's Care

Premises Fire Risk Assessment dated July 2018 had been taken. We were only given records to confirm one item had been completed. Basic checks on fire safety equipment had been completed regularly by staff.

The deputy manager told us that the personal emergency evacuation plans (PEEPs) in place for everyone at our last inspection had been updated. We found that PEEPs for two people who required significant support to evacuate the premises had not been reviewed and updated since April 2017. Again, some people's PEEPs did not include plans to support them evacuate in an emergency if they were in bed.

Staff did not know what actions to take in an emergency. Staff did not describe the fire evacuation process the manager told us was "essential for all staff to follow". Fire drills had taken place since our last inspection but some staff had not been involved in these, including one staff member who worked at night when staffing levels were considerably reduced. Records of a fire drill in September 2018 stated staff had not been able to evacuate one person. The reason for this had not been investigated to make sure the person could be evacuated in an emergency.

The provider had failed to assess risks and mitigate risks to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People continued to be at risk from unsafe medicines management. Action had been taken since our last inspection to prevent medicines from being stored at excessively high temperatures. However, medicines requiring refrigeration had been stored below the manufactures minimum recommended temperature of 2°C on 47 occasions since the end of August 2018. Storing medicines below the manufacture's recommended temperature can reduce their effectiveness. Medicines which require refrigeration must be stored between 2°C and 8°C. Records of some medicines had not been checked and countersigned to confirm they were accurate, including hand written guidance about administration and stocks of some high risk medicines.

People continued to be at risk as their medicines were not always administered as prescribed. In June 2018 one person's specialist had required staff support them to gradually reduce their medication. Guidelines provided by the specialist had not been followed and the reduction had not begun until October 2018. No plan was in place to ensure that the medicine was reduced as the specialist required. Previously we found another person had not received their medicine as prescribed by their doctor. Staff had discussed this with the person's doctor and it was now being administered as the prescribed.

Stocks of medicines were not sufficiently monitored to ensure they were always available when people needed them. One person's medicine ran out during our inspection. On the first day of our inspection staff noted there was insufficient stock for the person to have their medicine the following morning. Staff took steps to order the medicine but it was not received in time for the person to take their morning dose. Staff told us after the inspection it had been received later that day and the person had missed one dose.

Risks that people would not receive their 'when required' medicines continued. Guidance had not been provided to staff about the administration of one person's pain relief medicine, including what it was used for, the maximum dose each day and other medicines it should not be taken with. This person was at risk of becoming unwell if they took too much of the medicine or took it with another medicine which contained the same ingredients.

The provider had failed to ensure the proper and safe management of medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action had not been taken since our last inspection to ensure staff were recruited safely. At our previous two inspections we found gaps in staff's employment history had not been explored and suitable references had not been obtained. At this inspection we found that these risks remained.

We looked at the employment records for three new staff members working alone with people. A full employment history had not been obtained for any of the staff, so the provider did not know the roles they had held and why they had left. One staff member had been dismissed from a role caring for vulnerable people. The manager told us that they had accepted the staff member's explanation for their dismissal and had not explored the reasons further to check that the staff member was of suitable character and had the skills to meet people's needs.

Checks on staffs' conduct in previous employment working with vulnerable people continued not to be completed. Any gaps in staff's employment history had not been identified and explored. There were no references for one staff member and checks on their conduct in previous care roles had not been completed.

The provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There continued not to be sufficient staff on duty to ensure people received safe care. Information we received before the inspection from whistle blowers was correct and staffing levels were significantly reduced at times putting people at risk. Staff deployment had not been planned to meet people's needs and keep them safe. The manager told us, 'It's obvious we don't have enough staff on duty to meet people's complex needs here". Following our inspection, the provider and the local authority discussed staff's ability to meet the three people's complex needs. The provider served notice and the local authority put arrangements put in place to move the people to other services.

The provider did not have a process in operation to determine how many staff were needed to provide the service. The manager told us 'ideally' they would deploy five care staff during the day. The deputy manager told us, "It changes every day but four in the morning and three in the afternoon and evening". Rotas showed that staffing levels fell below this daily. For example, only care three staff were deployed between 07:00 and 09:00 when people were getting up, washed, dressed and having breakfast and two staff were deployed between 21:00 and 22:00. Two people needed two staff to support them to move around, including going to the toilet and four people needed support with behaviours that challenged. A cook was not employed to work at the service and care staff prepared all the meals. Domestic staff worked from Monday to Friday but care staff were required to complete cleaning and laundry tasks at the weekends. The number of care staff deployed on a Sunday was also reduced.

Again, we observed that people sat alone for long periods of time with no interaction from staff. We observed four people in the lounge for 30 minutes. Two people sat passively for the whole time and did not engage with anyone or anything. Another person sat passively for 25 minutes also not engage with anyone or anything. A fourth person was supported to walk by staff but then sat passively for 20 minutes without interaction with anyone or anything.

Staff deployment was not planned to deliver the one to one hours commissioned by the local authority to meet people's needs. There was a difference between the number of hours the provider believed were commissioned and what had been commissioned. For one person the provider thought they needed to provide 15 hours less than the number the care manager had commissioned to meet the person's needs.

The provider had recorded the number of one to one hours on the 'staff daily tasks' sheet but neither the manager nor the deputy manager knew how this ensured that people received the hours in practice. If one person was having one to one this left other people without the individual assistance they needed. Records of the hours provided were not detailed and had not been analysed to ensure that people received the support they required.

Arrangements were not in place to make sure that staff have the right mix of skills, competencies, qualifications, experience and knowledge were deployed to meet people's individual needs. We observed one staff member administering people's medicines. Their competency to administer medicines safely had not been checked. A new staff member completed wake night shifts on 6 and 7 November 2018. The deputy manager told us they had "not had enough time to give (the staff member) any induction or training other than the fire exits" and would do this "as soon as I have time".

People continued to be at risk as agency staff, who worked alone at night had not been given the information or training they needed to provide safe care to people. Since our last inspection the provider had not implemented a process to make sure agency staff had information about people and the provider's systems. The deputy manager told us agency staff were shown the fire exits and had access to the people's care plans. Information about the training agency staff had completed had been obtained, however this did not include training to meet people's needs. One agency staff had not completed training in epilepsy. The deputy manager told us this was "essential" for working in the service. Some people required emergency medicine after having a seizure for five minutes. This reduced the time agency staff had to identify the risk and obtain support for from the sleeping staff member, 30 wake nights shifts had been completed by agency since 1 September 2018. The deputy manager told us, "It's not ideal having agency on at night because two of our residents have seizures and all have complex needs".

The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some improvements had been made to the cleanliness of the environment since our last inspection. However, further improvements were needed to ensure people were always protected from the risk of infection. Previously one person's bedroom smelt strongly of urine. The room had been redecorated and the person had a new bed. However, the room continued to have smell of urine. Records of cleaning we were shown during this inspection did not include detailed information about cleaning, including what had been completed when.

One person used equipment to assist them to take their medicine. We found that the equipment was dirty and a process was not in operation to regularly clean it. We also saw that a small pedal bin was kept on the work surface in the medicines room. The bin was overflowing and contained used disposable gloves and paper towels.

At the last inspection the provider had not been able to provide us with records of food safety checks and staff we spoke with were unaware that records of cleaning and the temperature of food and equipment should be maintained. We asked to see these records during this inspection. The staff member preparing food did not know what records the provider required to be kept. The deputy manager told us checks had been completed and recorded as required. They told us they would send us copies of these records however, we did not receive them following the inspection.

The registered persons had failed to ensure that the premises and equipment used by service users were

clean. This was a continued breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

The service continued not to be well led. At our inspections in April 2017, January 2018 and July 2018 we found that the provider lacked oversight of the service and there were multiple breaches of the Health and Social Care Act. The provider only attended the service briefly during this inspection and did not involve themselves in the inspection process, despite invitations from inspectors. We found that risks to people continued and effective action had not been taken address the breaches of regulation.

Following our inspection in January 2018 we took regulatory action against the provider, this action continues. Full information about the Care Quality Commission's (CQC) regulatory response to the serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

A new manager had begun working at the service in September 2018. They were also responsible for managing two other services the provider owned. The manager told us they had applied to CQC to become the registered manager of all three services. They told us they had applied several weeks before our inspection and the registration process had begun. The manager was not aware that their application had been rejected, because it contained inaccurate information, despite being notified of this two weeks before our inspection. The manager was supported by a deputy manager who had worked at the service since July 2018. They told us they should also receive support from a consultant employed by the provider but the consultant was no longer working for the provider and a new consultant had not yet been appointed.

People continued to be at risk of harm and abuse. Since our last inspection we had received three updates to the provider's improvement plan, these showed little improvement had been made. The manager told us, "[The improvement plan] doesn't really tell you what needs to be done". The improvement plan had not provided us with the assurance we needed to be confident the provider understood our concerns. We requested a more robust improvement plan before this inspection. The plan we received did not provide the reassurance we were seeking and we remained concerned about the systems and processes the provider had in place to make the improvements.
Improvements the provider told they had made to staff recruitment and the identification and reporting of safeguarding concerns, had not been made. The manager told us to make the necessary improvements to the service was, "a massive piece of work" and they needed "practical support", such as completing analysis and developing improvement strategies.

There continued to be a lack of leadership and direction and staff were not always held accountable for their responsibilities. The manager told us they would "lead by example, get my hands dirty and teach staff the new culture". However, we found they did not know people and the day to day operations of the service well. During our inspection they frequently deferred to the deputy manager to answer questions about operational matters, such as, which staff were working on that day or people's needs. The manager told us they had put systems in place to develop the staff team, including "training, supervision, support and encouragement to work transparently". These systems were not robust and effective and staff had not implemented changes the manager and deputy manager told us they had made. For example, all staff were

required to sign the minutes of staff meetings to confirm they understood what had been discussed and agreed. The minutes for October 2018 meeting had only been signed by the manager and deputy manager and neither was aware that staff had not signed them. When we brought this to their attention the deputy manager said, "Oh well, it was a good idea to check that everyone was on the same page but as so often here, the staff just do their own thing and they know they can because [the provider] is so kind [they] won't challenge any one". The manager had begun the disciplinary process for one staff member following concerns being raised about their practice.

A new shift handover system had been introduced to improve communication within the staff team, as important things such as appointments had been missed. The manager and deputy manager told us the new system had started on different dates, two weeks apart. Records had not been kept for each handover or concerns and there was a risk that concerns about people had not been followed up. For example, the records showed that one person 'has seemed agitated at times today. Noticed waxy left ear in evening- monitor for ear infection'. No further checks or action were recorded and the manager and deputy manager were not able to tell us if the concern had been resolved.

The manager told us the provider had purchased 'the top package' of policies and processes from an independent company, which they planned to introduce to the service. They told us the policies had been amended to reflect the ways the provider worked by someone who was not involved in the day to day operations of the service. The policies were not in operation at the time of our inspection.

The provider's statement of purpose had not been amended since our last inspection and was out of date. The service continued not to be delivered in accordance with statement, for example, 'staff with the relevant mix of skills to meet all of our clients' needs' had not been deployed as it required. The manager told us the statement of purpose did not clearly describe the culture at the service and they planned to update it. They were not aware of the requirement under regulation 12 of the Care Quality Commission (Registration) Regulations 2009 to provide us with written details of any revisions.

The provider continued not have oversight of the service. They had begun monthly senior management meetings to plan and check improvements at the service. The first meeting had been held in October 2018. Minutes of the meeting did not include plans to make improvements and had not been agreed by the provider. The provider had completed an audit of the service in October 2018 and planned to complete these monthly. We looked at the October audit and found shortfalls in staff recruitment and rosters had not been identified. Action had not been planned to address areas where 'corrective action' was required, for example in relation to 'general maintenance, external and internal and décor'.

Checks and audits continued not to be effective. The provider's improvement plan stated, 'List of audits are now in place and are being completed by the Manager and Deputy'. Medicines audits had not been completed regularly since our last inspection. Risks to people had not been identified so action could be taken to address them and prevent them from occurring again. We looked at one weekly medicines audit completed on 18 October 2018. No further checks on medicines, including high risk medicines had been completed. The manager told us the staff member completing the checks had left and this responsibility had not been given to anyone else. They told us it was their intention to begin completing monthly checks on all areas of the service but they had not begun these. The deputy manager told us, "We need someone to show us how to do audits in the right way. I know how to do audits and they're all in place but I need someone to oversee that". Audits had not been completed to check that the improvement plan was effective and identify if any amendments were required.

The provider, management team and staff continued not have access to the information they needed to

provide a safe service, because records about most areas of the service were inaccurate and incomplete. Before our inspection, local authority staff told us records they had looked at during an investigation were muddled and incomplete. Some which could not be found during their visit, had not been supplied to them afterwards. We found the same concerns. No effective system was in place to achieve and retrieve records about people's care and treatment. When looking at records of accidents and incidents for three people, we found that their records had been filed with other people's records and other people's records had been filed with theirs. Other records of incidents could not be found. Records of accidents and incidents contained limited information about what had happened. The manager told us they no longer believed an analysis of incidents and accidents they had completed was based on "fact" because, "there are so many gaps and missing entries and they don't reflect what happened".

The culture of the service was not open and transparent and the provider had not invited people, their relatives, staff and stakeholders to share their views of the service and suggest improvements. The deputy manager told us, "Resident's meetings are very important as we need to get feedback from the guys about their home and that's a key way to do it". The process was to hold monthly meeting but records showed the last meeting had been held in July 2018 and no further meetings were planned. The manager did not know if the provider had informed people, their relatives and stakeholders about the outcome of our last inspection or shared their improvements plans. We spoke some people's funding authorities following our inspection. They had not been informed of the outcome of our inspection and had not been asked for their views, suggestions or support.

The provider had continually failed to operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider continually failed to seek and act on feedback from service users and other relevant people on the services provide, for the purposes of continually evaluating and improving the services. The provider had continually failed to maintain accurate and complete records. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously we found that the provider did not fully understand their responsibilities with regards to running a regulated service. Statutory notifications, including the authorisation of Deprivation of Liberty Safeguards (DoLS) and potential incidents of abuse had not been sent to us as required. This continued and again we had not been informed of a DoLS authorisation and potential incidents of abuse. The manager did not know that some events including a serious injury or DoLS authorisation needed to be notified to us. Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service so we can then check that appropriate action had been taken.

The provider had failed to notify CQC of notifiable events. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not conspicuously displayed their rating at the service and the rating and inspection report from our January 2018 inspection were on a notice board in the entrance hall. We told the manager and they took action to make sure the rating from our July 2018 inspection was displayed on the notice board. The provider did not have a website.

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 provider had failed to notify CQC of notifiable events. Regulation 18(1)(2)(b)(e)(4B)

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess risks and mitigate risks to people. Regulation 12(1)(2)(a)(b) The provider had failed to ensure the proper and safe management of medicines. Regulation 12(1)(2)(f)(g)

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

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 had failed to protect people from abuse. Regulation 13(1)(2)(3)

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that the premises and equipment used by service users were clean. Regulation 15(1)(a)

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had continually failed to operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. Regulation 17(1)(2)(a) The provider continually failed to seek and act on feedback from service users and other relevant people on the services provide, for the purposes of continually evaluating and improving the services. Regulation 17(1)(2)(e) The provider had continually failed to maintain accurate and complete records. Regulation 17(1)(2)(c)

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. regulation 18(1)(2)(a)

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. Regulation 19(2)(a)(3)(a)

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.