Venetian Healthcare Limited

The Grove

Inspection report

181 Charlestown Road
Charlestown
St Austell
Cornwall
PL25 3NP

Tel: 0172676481
Website: www.grove-charlestown.co.uk

Date of inspection visit:
20 July 2021

Date of publication:
16 November 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Grove is a residential care home providing personal and nursing care for up to 38 people. At the time of the inspection the service was supporting 26 people.

People's experience of using this service and what we found
We last inspected the service in May 2021. At that time, we had concerns regarding the management of the service and the service was rated Requires Improvement. Since that time the management situation has not improved. Before the inspection we were aware the previous interim manager had left. An office manager was in post at the inspection. They had made improvement in some of the administrative systems. Since 2016 the service had not always met regulatory requirements. At the last inspection we identified checks and monitoring had not always been completed. At this inspection we found no improvement. Systems and processes were being frequently changed and not effectively implemented, embedded or monitored. This demonstrated governance systems were not effective.

.
There remained a requirement for the service to have a registered manager as part of a condition of registration. An interim manager commenced employment at The Grove shortly after the site inspection.

At the previous inspection staff told us they felt communication was not effective. At this inspection we found no improvement. Communication between people, staff and families was not effective. People and staff had approached CQC and the local authority with their concerns as they felt they were 'not heard' by management.

At the last inspection we found medicines records were not in place or consistently completed. At this inspection we found further deterioration in medicines management. There was no oversight, checks or audits in place. Records of medicines were not always recorded as required. Records showed gaps, so it was not possible to evidence if people had been given their medicines.

At the previous inspection we found risks were not always assessed and monitored. At this inspection there had been no improvement. Care plans and risk assessment information was not up to date. There had been no reviews of people needs for some time. Some people's needs had changed. This meant staff did not have an up to date record in order to respond to people's current needs. However, staff knew people well and there had been no impact on the support people received. Agency staff had limited knowledge of people's needs. Handover records did not contain any detail of people's health conditions or needs.

At the previous inspection we identified the service was not monitoring reports of accidents or incidents in order to identify any trends or patterns. No improvement had been made during this inspection. There was no evidence the service reflected and learnt from issues and incidents when things go wrong. When things went wrong reviews and investigations were not sufficiently thorough.

The provider remained under the local authority's whole home safeguarding procedures due to the high number of alerts made over recent months. The commission had also been made aware of some of the concerns raised through safeguarding. Some of these were being investigated at the time of the inspection. The management team were cooperating with the safeguarding team, quality assurance team and CQC to investigate these concerns.

There had been significant changes in the staff team in recent months. There was currently a heavy reliance on agency staff. We observed staff supporting people in a task centred way rather than person centred, this was due to staffing levels and agency staff not being familiar with people using the service. Staff told us they were 'rushed' most of the time. Other staff told us things were getting better because they had a new staff roster which meant they had a regular shift pattern. There was no evidence of staffing levels impacting people's safety.

The service was not ensuring satisfactory recruitment checks were in place to ensure staff were recruited safely. Files requested could not be located. Gaps in employment not explained or followed up. References from previous employees were not always followed up.

The service was not always following its own guidance for COVID-19. A checklist at the entrance instructed staff to take visitors temperatures when entering the home. On arrival we were asked for evidence of a negative Lateral Flow Test (LFT), we did not receive a temperature check.

Most people we spoke with were satisfied with the measures being taken when visiting their relatives. People told us they had LFT tests and waiting for the result before being allowed their pre booked visit to their family member. However, one person told us they had not always been asked to wait for the result before visiting in the external rooms the home provides. We have reminded the provider of the necessity of ensuring all visitors receiving a negative test before they visit their family member.

At the previous inspection we found cleaning checklists had not always been completed. At this inspection we were assured checklists had been reviewed and were consistently completed by the housekeeper.

At the previous inspection the provider could not provide evidence to demonstrate fire, legionella and equipment checks were being done. At this inspection we saw evidence these checks had been carried out. Work to meet fire regulations was continuing.

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 22 June 2021) and there was a breach of regulation. The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve. We did not receive the action plan prior to this inspection. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to staffing and the quality of care people received. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 COVID-19 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.

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.

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 monitor the service.

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 infection control, good governance and staff training at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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.

The Grove

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by three inspectors.

Service and service type
The Grove 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.

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.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, office manager, and three senior care workers, care workers and the chef.

We reviewed a range of records. This included four care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and senior manager minutes.

After the inspection
We continued to seek clarification from the provider and interim manager to validate evidence found. We looked at a number of records relating to staffing and governance. We spoke with a professional who visits the service and liaised with the local authority. We spoke with four relatives.

Requires Improvement

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 remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare 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 there was a repeated breach of regulation 12

● Care plans did not include the current level of risk for people as staff had not had access to care plans for a period of time. This had the potential to put people at risk of harm. Staff were not always following the guidance in people's care plans. For example, one person required timely interventions to reduce the risk of skin damage. Staff were not following this guidance in accordance with the care plan. There had been no negative impact on the person, but staff were reminded to follow the guidance in the care plan. Staff understood people's needs and how to respond to them, although records were not up to date.
● People's care records stated they should be reviewed monthly. All records we looked at showed reviews were not taking place monthly. For example, a bed rail assessment had not been updated since November 2020. A moving and handling assessment had not been reviewed since May 2020 and a personal care plan not reviewed since February 2021. This person's needs had changed. There was evidence of routine disregard for monitoring risk or ensuring safe practice.
●Records to inform staff of the support people needed were not consistent. This was particularly important in light of the reliance on agency staff who might not have been familiar with people's needs. Shift handover sheets did not contain any details of people's health conditions or needs.
●Care plans showed some people needed their food and fluid intake monitoring. When we asked staff if we could see the records for one person, they told us the person was no longer being monitored. The instruction for staff was incorrect.
● We identified a number of people had significant weight loss recorded. There was no evidence in care records of action being taken. However, when we spoke with senior staff they told us they were aware of weight loss and were monitoring and had shared with health professionals. We identified there had been no impact on people and that it had been a recording issue. Following the inspection, we had shared these concerns with the appointed manager. They assured us they had been identified this issue and they had instructed all staff to ensure any responses to people's health needs were recorded.
●Care files contained body maps to record when people had any mark or injury. Some people had several

body maps on file where staff had noted they had identified bruising. There was no record to show any action had been taken in response to this to either identify the cause of the bruising or to minimise the risk of recurrence.
● Some people had periods when they were confused and distressed leading them to acting in a way which could put themselves or others at risk. There was no guidance for staff on how to support people at these times. Care plans did not include information about how to support people who displayed anxiety or challenges. A staff member told us, "Not had any training in how to manage challenges."
● There was no evidence the service reflected and learnt from issues and incidents when things go wrong. There was limited use of systems to record and report concerns. When things went wrong reviews and investigations were not sufficiently thorough.

The provider had failed to take suitable action to ensure peoples risks were being assessed and monitored. This meant they were in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the previous inspection the provider could not provide evidence to demonstrate fire, legionella and equipment checks were being done. At this inspection we saw evidence these checks had been carried out. Work to meet fire regulations was continuing.

Staffing and recruitment
● Staffing levels were not always sufficient to ensure people's needs and preferences were met. We heard one person saying they liked to have a shower when the weather was hot. They commented, "Trouble is I can't have one at the weekend because there's no one to help."
Staff had concerns about the staffing levels. Staff consistently told us it had recently been very difficult due to several staff leaving at the same time. Comments included, "It's been a tough few month. It's good we work closely together as a team, but just getting through what we have to do with no extra time to sit down and chat with residents" and "We are always short of staff, I think people are getting their care needs though. It is getting better." We observed this to be the case during the inspection. We concluded that the provider was not delivering enough staff to carry out personal care in a timely manner and meet peoples social and emotional needs.
● Staff knew people well and had supported each other during the COVID-19 outbreak. However, staff told us they had felt unsupported and not appreciated. They said the constant changes in shift patterns had resulted in staff leaving. However, they said there had been positive changes recently including a roster that ensured staff had regular shift patterns. Staffing levels had improved although staff told us they felt stretched and the focus was on completing tasks rather than person centred care and support. Some previous staff members were going through recruitment processes to come back and work at the home. A staff member told us, "It will be better when we get a static staff team."

The provider did not ensure continuity in staffing levels which meant care and support was task driven and not person-centred. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We asked to see recruitment records for a named member of staff. The records could not be located on the day of the inspection. Another member of staff showed gaps in the employment checks. The system appeared disordered. Information we requested was either not available or in other locations. The office manager and provider agreed the records needed to be audited. The provider commented; "It's been on my radar for a long time."
●Systems to ensure staff were suitable for the role were not robust. References from past employers had not

always been followed up.

Failure by the provider to ensure safe and effective recruitment systems had the potential to put people at risk. This was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At the last inspection the provider had failed to ensure medicines were managed and administered as prescribed. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not taken necessary action to meet the requirements of this regulation and there was a repeated breach of Regulation 12

● There was no management oversight, checks or audit process in place to monitor and manage the safe administration, management and storage of medicines.
● Medicines that required stricter controls were held by the service but not recorded as required by law. Records showed that some medicines, which required stricter controls, were being held at the service, but these were not found. This meant these medicines were unaccounted for. This concern had not been monitored or identified prior to this inspection. Following this inspection, the newly appointed manager reported to us they had reviewed all medicines and had put systems in place to ensure all concerns around medicines management were addressed.
● Prescribed creams were not dated when opened for use. This meant it was not possible to know when they should be disposed of and no longer effective to be used. Records of when people's creams were applied had not always been completed. This meant it was not possible to know if they had been applied as prescribed.
● Body maps were in use so that staff were guided to which site to use when administering injectable medicines and pain-relieving patches. These were not always completed. This meant staff would not know which site to use, when giving the next injection or applying the next patch. It is important that injection sites are rotated to prevent skin damage.
● Medicine Administration Records (MAR) were not always completed when prescribed medicines were due to be given. This meant it was not possible to evidence if people had been given their medicines as directed.

The failure of the provider to ensure the safe management, storage and recording of medicines is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people administered some of their own medicines. This had been assessed and added to their care plans.

Systems and processes to safeguard people from the risk of abuse
● The provider remained under the local authority's whole home safeguarding procedures due to the high number of alerts made over recent months. The commission had also been made aware of some of the concerns raised through safeguarding. Some of these were being investigated at the time of the inspection. The management team were cooperating with the safeguarding team, quality assurance team and CQC to investigate these concerns. People told us they felt safe, "I have lived here for some time. I feel very safe" and "The staff are very kind and patient."
● Staff we spoke with understood the principles of safeguarding and keeping people safe from abuse.

Preventing and controlling infection
At the previous inspection we found cleaning checklists had not always been completed. At this inspection we were assured checklists had been reviewed and were consistently completed by the housekeeper.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. People told us they had LFT tests and waited for the result before being allowed their pre booked visit to their family member. However, one person told us they had not always been asked to wait for the result before visiting in the external rooms the home provides. We have reminded the provider of the necessity of ensuring all visitors receiving a negative test before they visit their family member.

● The service was not always following its own guidance for COVID-19. A checklist at the entrance instructed staff to take visitors temperatures when entering the home. On arrival we were asked for evidence of a negative Lateral Flow Test (LFT), we did not receive a temperature check.

We recommend the service follows its own guidance and supports the Department of Health and Social Care guidance on home visiting.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Toiletries such as a soap bar, shampoo and a nylon body scrub were seen in a shared bathroom. This increased the risk of cross contamination. We advised the provider of this and they took immediate action to remove it and advise staff.

We have also signposted the provider to resources to develop their approach.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The provider retained a visiting pod in the garden and external entry to a lounge. The provider did not feel it was safe for visitors to enter the service. People were encouraged to go out into the community with their relatives or friends. Relatives told us, "It's been a very positive experience. Haven't seen [relative] in many months," "I feel confident about the way they manage visiting. They are taking it safely." One person felt the service did not always manage the bookings well. They told us, "Sometimes the staff don't come to the door even if they know you have an appointment. This means my half hour gets eaten into". We discussed this with the provider at the end of the site visit. They told us they would review the system and discuss with the staff team.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● 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 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.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection, the provider had failed to ensure effective communication with people and their relatives. We were not assured the culture and knowledge of the staff team produced consistently good outcomes for people and not ensuring areas of requires improvement were identified or acted upon. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not taken the necessary action and the regulation continued to be breached for the second time.

● The service is required to have a manager registered with the Care Quality Commission. 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. At the time of this inspection the service had not had a registered manager since the beginning of February 2021. Since 2016 there had been three registered managers and gaps filled with interim managers. Inspections of the service, which took place in 2017, 2018, 2019 and 2021 had not met regulatory requirements and required improvement. This demonstrated governance systems were not effective. One registered manager had refused an exit interview. There was no evidence of exit interviews for previous managers or reasons why registered managers left. We were told, "I have had six managers in my time here, it has been difficult. I have not had any supervision for over a year. We are always short of staff. I think people are getting their care needs though. It is getting better." Relatives said, "There has been a lot of changes in managers. It's not been good, "There is a new manager and office manager now I think things will get better."

● Staff recognised that the lack of consistent leadership had impacted on the service's performance. Staff told us that for a period of time prior to May 2021 they had not been able to access some parts of people's care planning records. Records we looked at showed no reviews and updates had occurred during this period of time. This had the potential to pose risk to people as staff relied on the manager informing them of any changes or directives needed to meet people's needs. The service was task centred and not person centred. This meant people were not placed at the centre of the service and treated as a person first. Staff told us, "It's been so difficult for us, not having the information we needed. It's going in the right direction now though," "It's just been awful a lot of the team left. No proper direction" and "The door was more often than not closed. We didn't get proper meetings". This demonstrated significant shortfalls in the way the service was led.

● We required an action plan following the inspection in May 2021. We were not provided with an action

plan by the date requested. During the inspection the provider showed us an action plan that had been prepared but not delivered to the commission. This was further demonstration of inadequate oversight by the provider of regulatory requirements.

● At the previous inspection in May 2021 we found audits and checks of the service had not been consistently completed. Those that had been completed had not identified all areas requiring improvement. At this inspection we found auditing systems were inadequate. Some records we asked for were either not available or limited in information. We observed an environment audit and infection control audit from March 2021. The environment audit identified some areas where there could be improvement, for example hoists and items cluttering the home. There was no evidence this had been actioned or overseen by the provider. In June 2021 a more comprehensive environmental audit had been completed using a traffic light system to identify which areas required the most urgent work. Care plan audits had not been completed since December 2020; Medicine audits had not been completed. The registered provider was not aware of some of the issues we found in the home even though they were visiting three days a week. The clinical lead worked remotely meaning they had limited overview of the service and relied on information provided by the manager.

● During the period of time the provider was not able to access the service due to COVID-19 restrictions they had relied on information shared by the interim manager at meetings. They had not requested evidence to further assure themselves of the management of the service. For example, at the meeting in April 2021 they had not requested sample evidence of care plan reviews which the manager stated had almost been completed. We found no evidence care plans had been reviewed in this timescale. The minutes reported the manager answered 'yes', to the question. We found no evidence to support this response. Another example was housekeeping audits. The manager had reported they were up to date. There were no housekeeping audits available for inspection and therefore this information was not correct. This meant systems for identifying, capturing and managing organisational risks and issues were ineffective.

The provider's governance systems remained ineffective in improving the service people received. This was part of a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the previous inspection the provider could not demonstrate evidence to show equipment and servicing utilities had taken place. At this inspection the service provided evidence current certificates were in place for Legionella, Gas and Electrical work. There was work being undertaken to ensure all fire regulations were addressed. This included a new external escape and a sprinkler system currently being fitted to the second floor of the home. This floor was currently out of use during the ongoing work.

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

● The provider had not ensured requirements found at the last inspection had been met. The provider had relied on information delivered verbally about the running of the service. They had not been assured with evidence that action had been taken to meet breaches of regulation.

● The provider had not ensured there was clarity about roles and responsibility and accountability.

● There had been four registered managers since 2016. In addition, several interim managers had been in post. This contributed to ineffective systems for identifying and managing organisational risks.

Continuous learning and improving care

● At the previous inspection the provider acknowledged they had been disappointed with the deterioration in the service when they returned in Spring 2021. However, at this inspection we found not enough improvement had taken place and the service had deteriorated further.

● Throughout this report there was evidence the provider did not understand the principles of good quality assurance. For example, lack of audits, care plans not reviewed or updated. However, the recent employment of an office manager had helped to begin to improve administrative systems. Staff told us things were beginning to improve. They told us, "It's been really difficult, but we now have access to the information we need to do our job." An interim manager was due to commence the week following the inspection.

The provider was not meeting the condition of registration to have a registered manager employed at the service. This was part of a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Relatives raised concerns that changes in the service had not been communicated well to people, which had caused them anxiety. For example. A family member did not feel the manager had communicated information about a concern they had raised.

● Communication between people, staff and families was not effective. People and staff had approached CQC and the local authority with their concerns as they felt they were 'not heard' by management. Staff told us they were 'disillusioned' by the constant changes in management. People told us, "It just seems to go on and on. The constant changes do not help any of us." Relatives said, "It is disheartening" and the communication with managers had been "poor," "Poor communication with the management team," Wasn't told about staff and managers leaving" and "Poor communication. Never tell us of any changes".

● Some staff told us they had experienced a lack of support when raising issues. For example, how the staff rota had been causing anxieties, due to staff not knowing, until short notice what shift patterns they were working. Not having access to people's care plans. However, the office manager had recently made changes to the staff rota and staff told us it was working much better. One staff member told us, "Knowing what I am doing for a two-week period is so much better." Senior staff told us they now had access to all care plan information in order to provide care and support to people.

● The constant changes in the management of the service meant there was no continuity. This had resulted in a large number of staff resigning from their posts and the need for agency staff. Concerns about this had been raised during a recent resident meeting. Two people raised concerns about the care provided by some agency staff. Commenting, "Generally they [agency staff] don't want to do anything." One person asked what was happening about The Grove management and what would be in place in the future. Another asked for a letter setting out the management structure with an idea about what the future team would look like. Assurances had been given but the request for a letter setting out the changes had not been complied with.

● During the COVID-19 period meetings with staff and residents had been limited. This had commenced again in May 2021.

● There was no evidence of effective systems in place to gather the views of people living and working the service. However, the recent resident meeting had encouraged people to discuss their views about the service they received. Five relatives told us there had been no quality assurance and they had not been asked for their views of the service.

● People were not receiving person centred care and support. Fluctuations in staffing levels meant staff were task orientated. They told us they only had time to carry out tasks. Staff said, "Look at the time [11:30] we are only just finishing getting residents up and we haven't stopped," "It would be lovely just to have the time to sit down with residents". It just doesn't happen." A professional who visited the service, told us it was not organised. Systems were not effective.

The provider had not taken action to improve the services governance systems. Communication remained ineffective. Management and staff did not understand the principles of good quality assurance and the service lacked good leadership. This was part of a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The local authority were working with the management team in order to improve the services people received.
- The service worked in partnership with health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that the care and treatment of service users was appropriate, met their needs and reflected their preferences.

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 failed to ensure safe and effective recruitment systems.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken all necessary action to protect people from risks. The provider failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that the systems and processes in place to assess, monitor and improve the quality and safety of the services provided were fully or consistently effective.

The enforcement action we took:

Warning Notice