Roborough House Ltd

Roborough House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Roborough House is a nursing care home that provides personal care for up to 44 people. At the time of the inspection 40 people were living at the service. Roborough House supports people with a range of complex needs including their mental and physical health. The service is in a large detached building split into three units with their own communal areas over two floors, with a lift for people who may have mobility needs. The service is set in its own grounds on the outskirts of Plymouth close to the moors, and has an indoor activities space.

People's experience of using this service and what we found.
Many people were not able to tell us verbally about their experience of living at Roborough House. Therefore, we observed the interactions between people and the staff supporting them. We received mixed reviews from professionals, staff and some people living in the home on how the home was run. Professionals told us the management did not always engage with them and some families also said they'd tried to contact the management without success.

We last inspected the service in November 2020. At that time, we had concerns regarding the medicine's management, and that systems and processes in place were not robust enough to identify some areas for improvement.

At this inspection we found the issues with both medicines and the audit systems and processes remained the same. Medicines records showed that people did not always receive their medicines in the way prescribed and when they did, records did not always show that this was the case.

The service did not have suitable safeguarding systems in place to protect people from abuse. Safeguarding incidents had not been followed up with the local authority's safeguarding team. Notifications were not sent to CQC when required to report accidents, incidents and safeguarding concerns.

Infection control procedures were not always being followed in line with current government guidance. Government guidance about COVID-19 testing for visitors was not being followed.

During the inspection we could not be sure all staff had received updated training as no training record was made available. We received the training record after a second request. However, no names of staff or dates of training completed was recorded. Staff did not always receive regular support or induction training. There was a high use of agency staff. One relative said; "Staffing has gone down a lot, you see different faces all the time."

The registered manager and provider did not always have clear oversight of the service. Audits, systems and processes were not always completed.

Food and fluid charts did not have all information recorded consistently.

The environment was safe and there was equipment available to support staff in providing safe care and support. Health and safety checks of the environment and equipment were in place.

People and their families were provided with information about how to make a complaint and details of the complaint's procedure were displayed at the service. A relative informed us they had not received a response to concerns they'd raised.

Staff were observed as attentive, kind and caring. A relative said; "I think the home is absolutely amazing in terms of caring. The staff are so loving and caring."

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

Rating at last inspection
The last rating for this service was requires improvement (report published 6 January 2021) and there were breaches of regulation. At this inspection we found that not enough improvement had been made and the provider was still in breach of these regulations. We also found other breaches of regulation.

Why we inspected
We carried out an unannounced inspection of this service on 24 and 30 November 2020. Breaches of legal requirements were found.

We received concerns in relation to safeguarding people, medicines, lack of suitable equipment on site to meet people's needs safely, charts not being completed, and paperwork not always being made available when requested, including care plans. As a result, we undertook a focused inspection to review the key questions of safe, effective, 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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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.

At this inspection we have identified continued breaches in relation to governance, risk and monitoring systems. We have identified breaches in relation to safeguarding, medicines, infection control and good governance 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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Roborough House

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 Health and Social Care Act 2008.

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
Three inspectors, including a pharmacist inspector carried out the site visit of this inspection. An Expert by Experience who is a person who has personal experience of using or caring for someone who uses this type of care service, carried out phone calls to relatives and friends.

Service and service type
Roborough House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Roborough House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

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 professionals who work with the service. Healthwatch contacted us about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 four people who used the service and five relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, nurses and carers and ancillary staff. We received information from four professionals.

We reviewed a range of records. This included four people's care records, and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our inspection in November 2020 we found the provider had failed to ensure the proper and safe use of medicines. This was a breach of regulation 12 (Safe care and treatment).

During this inspection we found the situation had deteriorated. The provider had failed again to ensure the proper and safe use of medicines. This was a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines records showed that people did not always receive their medicines in the way prescribed. Six people's medicines administration records (MAR) had one or more gaps for regularly prescribed medicines. From these records it was not always possible to tell whether the person had been given their medicines or not. One person had a dose of medicine that was prescribed to be given at night, that had not been signed as administered until early afternoon on the day of our inspection. Staff told us this was the signature of a nurse who had worked the previous night, so it was not clear if or when this dose might have been given.
● Medicine audits did not highlight that stock of medication had run out. One person living in the service, who had recently run out of their important pain relief said; "They do not seem to have an effective ordering system."
● When creams or external items were prescribed these were ticked by staff on the MAR charts, meaning it was not possible to know who had applied these preparations. There were also gaps in these records so it was not possible to be reassured they were being applied as prescribed. Staff told us that they were planning to introduce a new system for recording these preparations.
● When people were prescribed medicines in the form of patches, charts were available for staff to record where these patches were applied. However, these were not always completed, meaning it wasn't possible to tell whether they were being removed and rotated correctly. There were no signed checks to show staff had checked the patch was in place on days when it was not due to be changed.
●When people were prescribed medicines 'when required' there were no person-centred protocols available to guide staff when doses might be needed. Staff told us these were in the process of being prepared for people.
● People could look after their own medicines if they wished. Staff had checked that this was safe, however there was no record to show that all risks had been assessed.

This demonstrates a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff received training in safe handling of medicines and had competency checks to make sure they gave medicines in a safe way. However, records showed medicines were not being managed safely. We saw some medicines being given safely at lunchtime.
● There were suitable arrangements for storing, and disposal of medicines, including those needing extra security. Temperatures were monitored to make sure medicines would be safe and effective.
● Medicines audits took place and some of the areas needing improvement had been identified. Plans were being put in place to make improvements. However, some of the issues we found at this inspection had been identified at our previous inspection in November 2020.

Systems and processes to safeguard people from the risk of abuse
● The service did not have effective systems in place to protect people from abuse.
● We received information that there had been people who had been seriously injured and required hospital treatment as a result of harm caused by other people living in the service. One person sustained a double fracture of the pelvis while a second person sustained a broken finger. This information had not been reported to the local safeguarding team, and no advice had been sought to protect people or prevent any further injuries.
●The registered manager was not fully aware of their responsibilities to raise safeguarding concerns. They had not raised serious safeguarding incidents with the local authority to protect people and had not notified CQC appropriately of concerns. We received information after the inspection that further notifications and safeguarding alerts had not been escalated to the local authority by the registered manager. Some of these backdated notifications and incidents were six months old.
● The training matrix received following the inspection did not show how many and which staff had completed safeguarding training.

The provider had not taken appropriate action to investigate or refer suspected abuse to the appropriate organisations. 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.

Assessing risk, safety monitoring and management
● People were not always protected from risks associated with their health, safety and welfare.
● Not all people's risk assessments were up to date. No updated risk assessments had been completed after people had injured other people due to behaviour that could be considered challenging. This placed other people at risk as staff did not have guidance on how to manage people's care safely.
● People's care plans did not contain sufficient information for staff to be able to support people with their behaviours and were not updated after incidents occurred. This had the potential to place the individual and others at further risk of harm. For example, it was recorded that one person had been pushed over in their wheelchair and had sustained a double pelvis fracture. The care plan did not provide staff with sufficient information on how to support either person appropriately to avoid this happening again.
● We observed one person experience periods of distress, anxiety and behaviour that could be seen as challenging. One agency staff member had been allocated to work on a one-to-one basis with this person. They informed us how difficult it was to manage this person's unpredictable behaviour and how they had sustained a recent minor injury from this person. The registered manager informed us this person was being found more suitable accommodation to meet their needs.
● We could not be sure that staff had completed updated fire safety training as the training record requested was not forwarded to us as requested. We received the training record after a second request. However, no names of staff or dates of training completed were recorded.

The provider had not assessed the risks to the health and safety of people receiving care. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most staff knew people well. However, a high use of agency staff, particularly for people who required additional support due to living with dementia, placed people at risk of staff not knowing people well. One relative said; "She is safe, there is always someone with her in her room and she looks well cared for." While another said; "There are always staff around, but they have a lot of agency staff at weekend." Another said; "At weekends they are always short staffed"
● We received information of concern that not all equipment had been maintained safely and some items could cause harm. We found that the equipment and utilities had been checked recently with the registered manager informing us of new equipment on order to keep people safe.
● Emergency plans were in place outlining the support people would need to evacuate the building in an emergency. Fire safety procedures and appropriate checks had been carried out.

Staffing and recruitment
● There were sufficient numbers of staff employed and on duty to meet people's assessed needs. However, the service relied on a high use of agency staff to fill these vacancies, particularly for people who required one-to-one support. This had the potential to put people at risk due to lack of knowledge of the service, people and systems. The registered manager stated more care staff were now working on shift. However, having only agency nursing staff on duty meant people might not receive consistent care. One relative said; "The only thing is there are different staff all the time, you do get a lot of agency staff."
● The staff said they worked additional hours, to help people have the staff they knew and trusted, as much as possible. Rotas recorded the use of six agency staff a day on many shifts. No systems were in place to show the number of staff needed to be on shift to keep people safe. We were informed the "Safer Staffing Ladder" dependency assessment tool showing what the safe staffing levels should be in the home, would be forwarded to us. This was received after a second request was made. This showed a guide to staffing levels needed in the service to help keep people safe. However, it did not separate the number of employed staff from the number of agency staff currently being used.

Systems and processes were not in place to ensure the service operated effectively to ensure compliance. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment practices were thorough and included pre-employment checks from the Disclosure and Barring Service obtained before new staff started work. However, we found that staff recruitment files were being put together during our visit and were presented to us in folders with many items duplicated. This made finding key recruitment documents difficult.

Learning lessons when things go wrong
● At the last inspection there were two breaches of regulation. These same two breaches have been repeated at this inspection. For example, we reported that systems and processes were not yet robust enough to identify some areas of improvement. We found this to still be the case. This showed lessons had not been learned.
● Accidents, incidents and safeguarding incidents were not always recorded or analysed so any trends or patterns could be highlighted and improvements made.
● Appropriate action had not been taken following any accidents or incidents deemed as safeguarding to minimise the risk of adverse events reoccurring. For example, referrals to the local safeguarding team for

advice and support to protect people.

Systems and processes were not in place to ensure the service operated effectively to ensure compliance. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Visitors were asked to test before each visit which is not current guidance.
- 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 somewhat assured that the provider was using PPE effectively and safely. Staff did not always wear their masks covering their nose and mouths.
- 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 somewhat assured that the provider was making sure infection outbreaks could be effectively prevented or managed. We were assured by the registered manager that staff were up to date with training, but we did not receive this information as requested.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

Visitors were asked to complete a test before each visit. However, this is not current guidance. Some visitors said they were unhappy about having to purchase their own tests at their cost. We discussed this with the registered manager, who was not aware that visitors were not needed to be tested prior to visiting.

We have signposted the provider to the government IPC (Infection Prevention Control) guidance to develop their approach.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- We requested the staff training records, but none were made available. Therefore, during the inspection, we could not be sure all staff had updated and relevant training. This included mental health, dementia and manual handling training.
- After the inspection we received an Immediate Action plan sent by the provider. It stated they would send us the "Training and supervision matrix and medication competency records." This took a further request to obtain. However, no names of staff or dates of training completed was recorded. This could place people at risk of harm because staff might not have the right skills to fulfil their roles.
- Staff informed us they had not been given the opportunities to discuss their individual work and development needs, including receiving any one to one supervision. The registered manager stated due to outbreaks of COVID-19 they had fallen behind with supervision. However, some staff stated they had not had any induction or supervision since they started at the service.
- No clinical supervision for nursing staff was carried out.

The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as necessary to enable them to carry out the duties they were employed to perform. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Food and fluid charts were held in people's bedroom or in a separate file on each of the three units. Not all information had been recorded consistently. Staff told us people had received adequate food and fluids, however when we looked at these charts in the mid-afternoon, they showed that some people had not eaten or drunk all day. Previous days food and fluid charts also had gaps in recording. The registered manager said they would ensure staff completed these records after each person received food or fluid.

Systems and processes were not in place to ensure the service operated effectively to ensure compliance. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were provided with healthy meals. Hot and cold drinks were served regularly throughout the day to prevent dehydration. One relative said; "The food is gorgeous, he loves it" and another said; "She likes the food; it always looks fresh and homemade."

● People who stayed in their rooms, either through choice or because of their health needs, all had drinks provided and these were refreshed throughout the day.

Staff working with other agencies to provide consistent, effective, timely care
●People were not always supported to maintain good health, nor were referred to appropriate health professionals as required. Health care professionals informed us they had contacted the service for information to monitor the health care of people they cared for. This information had not been sent after several requests.
● Professionals had not always been contacted when the service needed support to manage people's health or social care needs.

Systems and processes were not in place to ensure the service operated effectively to ensure compliance. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's individual needs had been assessed before they moved into the service. Records showed a new admission to the service had a pre-admission assessment completed.
● People were not admitted unless they had received a negative COVID-19 test before admission.

Adapting service, design, decoration to meet people's needs
● We received information of concern that manual handling equipment was not regularly maintained and, in some cases, was broken. We saw this equipment had been serviced and the registered manager informed us new items, for example slings, were on order.
● The physical environment was continuously being reviewed, updated and improved.
● People's rooms were furnished with personal belongings to ensure people felt comfortable with familiar items around them.

Supporting people to live healthier lives, access healthcare services and support
● There were records to show staff were monitoring specific health needs such as people's weight, nutrition and hydration and people's skin care. However, there were gaps in the records. A healthcare professional requested this information from the service and had not received it.
● Staff supported people to continue to mobilise independently. We observed staff offering support to people who used mobility aids.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Mental capacity assessments had been completed for people and, where required, appropriate applications had been made and received to deprive people of their liberty within the law. One relative said; "He is safe as he is on a DoLS."
● People were asked for their consent before any care was delivered. People, who were able to, had signed their care plans to indicate they agreed with their planned delivery of care.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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 our inspection in November 2020 we found the provider had been in breach of regulation 17 as they had failed to ensure that the systems to check the safety and quality of the service were robust, had failed to establish satisfactory governance arrangements and to maintain an effective overview of the home, or taken sufficient action to make the required improvements identified in the previous inspections.

During this inspection things had deteriorated. The provider had failed again to ensure that systems to check the safety and quality of the service were robust. No improvement had been made at this inspection and there was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and provider did not always have clear oversight of what was happening in the service. For example, at our last inspection we noted that the medicines audits had not identified inconsistencies in administration. Risks were not always assessed or assessments updated as required. We found these issues remained. Regular audits still had not taken place, for example, medication audits had not picked up errors and gaps in medicines administration. An audit on hygiene products had not shown the service had run out of cleaning wipes.
● No accident or incident forms were completed, and no analysis of accidents and incidents had been carried out to highlight any patterns or trends.
● There were no clear lines of responsibility across the management and staff team. When we requested information to be provided during and after our inspection, we had to request this information several times. Some information was not received without additional requests to the provider.
● Some staff did not always feel valued or supported. Staff confirmed a lack of induction when starting work at the service and no supervision. No clinical supervision had been carried out to support trained nursing staff in their role.
● The management did not always engage with external agencies and families. For example, a professional informed us they had requested information from the registered manager about the person they visited. By the conclusion of the inspection process this information had not been passed to this professional. One staff member informed us; "[Registered manager] does not respond to emails and does not respond to family."

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

● The registered manager and provider did not understand their role in terms of regulatory requirements. For example, notifications were not sent to CQC when required to report; incidents, accidents and safeguarding concerns that had occurred. We found safeguarding concerns recorded in people's individual daily records. However, these had not been reported to CQC or forwarded to the local authorities safeguarding team and there had been no follow up with professionals to seek advice to help protect and support people.

The providers did not notify CQC of all incidents that affect the health, safety and welfare of people who use services. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Notification of other incidents).

● We received minutes of the provider's Governance Committee meeting dated February 2022. These highlighted information on a person who had recently passed away but no death notification had been received by the commission. The commission had not received any notifications about people who had passed away in 2022.

The provider did not notify CQC of all deaths within the service. This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We received information that the registered manager did not always work with external healthcare professionals. Information requested by professionals on people's health was not received. This information would have helped professionals to plan any change in people's treatment.
● The provider's systems failed to ensure that people received person-centred care to meet their needs.
● A relative commented via Healthwatch UK, that they only "received lip service" to the concerns they raised, and nothing was done about them. Some staff felt unsupported with a lack of inductions and supervisions.
● People did not always receive good outcomes. For example, one person did not receive their much needed pain relief medicine due to ineffective auditing systems.
● We received information from staff that if they complained about the management they would be seen as troublemakers. This meant staff were less likely to whistleblow or raise important concerns.
● Some staff informed us they had not received support, training, professional development, supervision and appraisal to support them to carry out their duties. We requested additional information and received an email stating they would send us the "Training compliance by course" and the "Supervision matrix." After a further request to receive this information it was forwarded. However, the training record had no staff names or dates on when they had been completed.

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

● There was a friendly, though busy atmosphere in the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the last inspection the provider had failed to ensure the systems to check the safety and quality of the service were robust and had failed to establish satisfactory governance arrangements and to maintain an effective overview of the home, or taken sufficient action to make the required improvements identified in the previous inspections. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remains in breach of this part of regulation 17 (Good Governance).

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was no evidence available to demonstrate people's and relatives' views on performance of the service had been sought.

The provider had failed to establish satisfactory governance arrangements. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● Governance systems were still not being used effectively in the service to identify areas that needed improving. Audits and checks of the service had at times identified failings but not enough action had been taken to resolve them.

● There was limited evidence of the provider's ability to drive improvement at the service. Despite the last inspection report raising concerns, we found the same concerns raised at this inspection and the service had deteriorated overall.

● The registered manager's lack of co-operation with external professionals and training and supervision of staff resulted in a lack of improvement to people's care.

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

Working in partnership with others

●We were informed by some healthcare professionals that the service was not working effectively with them to ensure people's care needs were met. They said that it had been increasingly difficult to obtain information about the clinical wellbeing of people in the service. They went on to say that information requested had not been forwarded as requested.

The provider had failed to establish satisfactory governance arrangements. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The provider did not notify CQC of all deaths within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The providers did not notify CQC of all incidents that affect the health, safety and welfare of people who use services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as necessary to enable them to carry out the duties they were employed to perform.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe use of medicines and had not assessed the risks to the health and safety of people receiving care.

The enforcement action we took:

Issue an NOP to issue monthly reports.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken appropriate action to investigate or refer suspected abuse to the appropriate organisations

The enforcement action we took:

Issue an NOP to issue monthly reports.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were still ineffective in improving the service people received and systems and processes were not in place to ensure the service operated effectively to ensure compliance.

The enforcement action we took:

Issue an NOP to issue monthly reports.