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# Elizabeth House Residential Care Home

## Inspection report

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Date of inspection visit:
12 June 2019
13 June 2019
20 June 2019

Date of publication:
19 August 2019

## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Elizabeth House Residential Care Home is a care home which can provide personal care for up to 16 people. Accommodation is provided over two floors. The service supports people who have needs associated with ageing or are living with a dementia related illness. At the time of this inspection up to eight people were using the service.

People's experience of using this service and what we found
At our last inspection we found a wide range of concerns. At this inspection we found that insufficient improvements had been made. Elizbeth House Residential Care Home remained unsafe for people and continued not to be well led. The service provided to people had deteriorated.

Where people were at risk of harm insufficient action had been taken to ensure that the risks were fully assessed and understood by staff. Clear plans were not always in place or implemented to reduce risks to people. People were at increased risk of harm due to the provider's failure to take appropriate action when risks had been identified.

The provider failed to ensure there was a lack of robust evaluation of care, meaning concerns were not always identified and addressed. This put people at risk of harm. Governance systems had not been effective in identifying and addressing shortfalls and unsafe practices.

The building and equipment were not safe for people to use. The environment, including the fire detection system needed updating and refurbishment. Infection prevention and control practices were not always followed. This meant the provider failed to ensure people were protected against the spread of infectious diseases. The home was not satisfactorily clean. Medicines were not always managed safely.

Documentation was not fully completed, contained some inaccurate information and in some cases, was missing. This put people at increased risk of not receiving the appropriate, individual level of care they required. People's preferences and wishes were not always detailed in care plans and there was limited evidence that their views had been sought. People were not given opportunities to engage in meaningful activities.

Appropriate pre-employment checks of staff were not carried out. The provider failed to ensure people were protected from the risk of unsuitable staff being employed. Staff did not receive the training, induction and support they needed to carry out their roles safely. The provider did not ensure staffing levels and deployment met people's needs. People told us they liked the staff who supported them however, staff were on occasions, task focused and did not always respect people's dignity.

Safeguarding systems and processes were not always followed. Incidents had not always been notified to CQC in line with legal requirements. We are dealing with this outside the inspection process

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way and in their best interests; the policies and systems in the service did not support this practice.

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, with an inadequate rating in the well-led key question (published 24 December 2018). There was a breach of regulation 17 related to good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection the service had deteriorated to an overall inadequate rating and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to person centred care, dignity and respect, need for consent, safe care and treatment, premises and equipment, good governance, staffing, fit and proper persons employed, requirements of registered managers and notification of incidents 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 concluded.

Since the last inspection we recognised that the provider had failed to notify CQC of all incidents in line with legal requirements. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We referred our concerns to the local safeguarding authority and asked the provider to send us evidence of improvements and action points. This was used when decisions were made about our regulatory response.

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

The service was not safe.

Details are in our safe findings below.

**Inadequate**

**Is the service effective?**

The service was not effective.

Details are in our effective findings below.

**Inadequate**

**Is the service caring?**

The service was not always caring.

Details are in our caring findings below.

**Requires Improvement**

**Is the service responsive?**

The service was not responsive.

Details are in our responsive findings below.

**Requires Improvement**

**Is the service well-led?**

The service was not well-led.

Details are in our well-led findings below.

**Inadequate**

# Elizabeth House Residential Care Home

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Elizabeth House Residential Care Home 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.

The service had a manager registered with the Care Quality Commission. The registered manager was also the provider of the service. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first and third day of this inspection were unannounced. The second day was announced.

What we did before 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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and six relatives and friends about their experience of the care provided. We spoke with seven members of staff including the registered manager, a senior care worker, three care workers, the maintenance person, who also acted as cook and the cook who also worked as a care worker. We spoke with three visiting health professionals.

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

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. Some information we requested had not been provided to us at the time of this report including details of staff training refresher schedules, a policy on the use of CCTV and staff supervision records.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider failed to ensure risks to people were adequately assessed and managed.
- Risk assessments had not been completed by a competent person on the use of bed rails. We found gaps greater than national guidelines and people were at risk of entrapment. We raised concerns with the registered manager about this. When we returned on our third day of inspection we found that the registered manager had tied the rails to the headboard to mitigate risk. This this added more entrapment hazards.
- The provider had not ensured people safety in the event of fire. We identified a number of concerns about fire safety during this inspection. We shared these with the local fire service. The fire service visited the premises and found a range of serious issues. They have served an enforcement notice highlighting actions that have to be taken by the provider in a set timescale to ensure people are protected from the risk of fire.
- Where people sometimes displayed behaviour which may challenge we found the provider had not ensured there were behaviour management plans in place. Such plans give staff guidance on the actions they should take if a person is becoming anxious to calm the situation. This put people and others at risk should a situation escalate.
- Equipment in use was not always properly maintained. For example, we observed a person being moved using a frayed and worn hoist sling. We found a hoist taped together over the electrical control stored in a bathroom. This was an increased risk due to the presence of water.

This was a breach of regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Safe recruitment practices were not followed by the provider. Some people working at the service did not have satisfactory references and background checks with the Disclosure and Barring Service (DBS). We observed that these staff worked unsupervised at times with people.
- We were given assurances by the registered manager following our second day of inspection they would personally supervise staff without full recruitment checks. When we returned for our third day of inspection this had not been adhered to.

The provider failed to ensure safe recruitment practices were operated. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels did not always meet people's needs.
● We identified that at times only two carers were on duty. Some people required two staff to support them with personal care tasks and transfers. When the two staff were helping these people, it left other people unattended, or at times supervised by a volunteer or new member of staff. An observation identified that two people were left without any checks for at least 40 minutes. This put people at risk of harm due to lack of oversight.
● One staff member told us it was difficult for people to use the garden as it was not secure and staffing levels meant there was often not enough staff to give people the oversight they needed outside.

The lack of sufficient staff meant that people were not safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● In August 2017 an infection prevention and control audit of the service identified a risk assessment to minimise the risks of legionella bacteria developing in water systems was required. In the following two-year period the provider has failed to take action regarding this risk. This put people within the building at risk of harm as without a risk assessment and oversight the bacteria may develop without detection.
● The registered manager had analysed accidents and incidents. However, records related to this failed to show the actions taken after the incident or allow patterns and trends to be identified.
● We identified that one person had a number of falls in April and May 2019. Despite this, their care plan had not been reviewed since March 2019.

The failure to assess, monitor and improve the service meant people were put at risk of harm. 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
● People were at risk of infection due to infection control procedures not being followed.
● We observed gloves were not used when a staff member took a person's blood sugar reading.
● The building was not sufficiently clean. We found a thick accumulation of dust throughout the home. The service had no dedicated housekeeping staff and care/maintenance staff carried out cleaning tasks.
● Infection control audits had been undertaken on a two-monthly basis; however, these had been ineffective in maintaining a good standard of hygiene and cleanliness.
● We found an open pot of cream in a bathroom.

The providers failure to identify and respond to risk put people at risk of harm. Medicines were not managed safely. The lack of infection control measures increased the risk of cross contamination and spread of infection.

This was a breach of regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely. People did not have protocols in place for medicines they took 'as and when required' to provide staff with guidance as to when the person should be offered the medicine and how it should be used.
● One person received their medicines crushed in food or drink This was undertaken in their best interest however, was signed for by a staff member who did not administer the medicine.

This was a breach of regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People received their regular medicines as prescribed.

Systems and processes to safeguard people from the risk of abuse

● During the inspection we reviewed incident records and noted several needed to be report to the local authority and/or CQC. The registered provider could not provide evidence they had reported these incidents as required.

● Staff had received safeguarding training and were able to describe the signs of abuse they needed to look out for and report.

Inadequate

# Is the service effective?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- The provider failed to ensure people's nutritional needs were managed safely.
- Where people were at risk of choking or had swallowing issues there was a lack of guidance for staff. We found one person was recommended to have pureed food however this was not always provided putting the person at increased risk of choking. Staff including the registered manager showed a lack of awareness of the British Dietetic Association guidelines for people at risk in this area.
- We found there was a lack of monitoring of people's fluid intake. Fluid charts were not always completed consistently and accurately and did not state the minimum amount people should have to drink. We observed that one person was not offered anything to drink for two hours despite coughing and being at risk of choking.
- We saw staff using the incorrect amount of thickener in the drink of a person at risk of choking. The provider had failed to ensure there was clear guidance available to them to understand the correct measures. Using these products incorrectly add to the risk of the person choking.

The provider's failure to manage people's nutritional needs safely demonstrated a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The registered manager failed to ensure staff received the induction and training they required. Staff did not always have the appropriate skills and experience to support people safely and effectively.
- There were no records of recently employed staff receiving an induction into the service.
- The provider failed to protect people from the risk of unsuitable staff being employed. For example, a volunteer was working unsupervised with people, without any recruitment checks or training. We observed the volunteer help a person to eat who was at risk of choking. They also supported a member of staff with a person's hoist transfer without the necessary training to carry out these tasks safely.
- We received written assurance from the registered manager on 17 June 2019 that staff without full clearances and checks would be supervised. On 20 June 2019 we found staff without the required checks working without supervision. This included taking a person to the toilet.
- Newly appointed staff had not been given fire training and did not know the fire procedure when alarms were sounded.
- The cook did not have the required knowledge to identify different types of food for people needing specialist diets.

People were put at risk as staff were not appropriately inducted, trained and competent to carry out their roles effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Adapting service, design, decoration to meet people's needs
● The provider did not ensure the building was fit for purpose. For example, we identified on the first day of inspection a large sash window on the first floor did not have a restrictor on it. This meant it could open fully and posed a risk as people could fall from it. We brought this to the registered managers attention who immediately made the area safe.
● The service required redecoration and refurbishment. The registered manager told us they had a development plan for the home which we requested sight of. However, a copy of this was not provided to us.

● The service was cluttered with a lack of storage space. We found wheelchairs and a hoist stored in bathrooms and a medicine trolley used to store topical medicines in a shower room.
● Staff told us, "There's just not enough space." They said they struggled to support people effectively in the ground floor bathroom. A hoist was stored in this room which had to be removed each time.
● Flooring on the first floor was very uneven. Staff told us this made it difficult to push people using wheelchairs on it.
● The environment had not been adapted to meet the needs of people with dementia related illnesses.

The providers failure to ensure the premises and equipment were safe and suitable for people put them at risk of harm. This is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had not been adequately assessed and recorded.
● People's care files did not document any meaningful desired outcomes or goals.
● Some information in care plans was contradictory or missing. For example, medicine lists in people's files did not match those on people's medicine administration records.
●The registered manager stated people's needs were reviewed monthly however could not provide evidence to support this. We identified one person's care plan had not been reviewed for over five months at the time of inspection.
● People's pain management plans did not state how they would express pain if they were unable to verbalise this. This issue was highlighted in the previous inspection of the service but had not been addressed.

The provider had failed to carry out a full assessment of each person's up to date needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One relative told us they were involved in the care planning process for their relative. They said, "The family are included in the review meetings and they keep us informed of any changes or recommendations to improve [person's] care."

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

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● DoLS applications were not always made appropriately. We identified that one person had previously left the building and displayed behaviour which suggested they may be unhappy in their placement. They had a care plan in place which highlighted they were unable to use the keypads in use on the doors. They were therefore, restricted in their movements. The registered manager told us they believed the person may lack capacity to make decisions in this area. They told us they were going to submit a DoLS assessment application. However, at the time of inspection, no DoLS application had been made and no best interest decision was in place.

● People had not always had their capacity assessed to agree with restrictions which were placed on them. For example, some people had bedrails in use. We were not provided with evidence that they had consented to this or evidence that they were being used in the person's best interests if unable to consent.

● We found that communal areas of the building had cameras in use. We found some people had signed their agreement to this however it was unclear how some of the people's capacity to agree to this had been assessed. The purpose of the cameras was not clear and when we asked the registered manager for their policy around this, but this was not provided.

● Best interest decisions that were in place did not show the involvement of relevant others, such as families in the decision-making process.

● Some people's relatives had signed their plans of care however there was no evidence available that they had the legal authority to do so.

The provider had failed to meet the requirements of the Mental Capacity Act 2005. This was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The service worked with other agencies to provide consistent care for example, district nurses and GP's.

● Some health professionals they told us they felt that staff did not have the autonomy they needed to make decisions about people's wellbeing. For example, when the registered manager was not on-site care staff had to contact them first to get approval to call medical services. Health professionals felt this could delay someone getting the medical care they needed.

● Guidance from professionals, such as that provided by the Speech and Language Therapy service was not always clear in people's care plans.

● Staff accompanied people to medical appointments if needed.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

● People's privacy and dignity was not always respected. For example, we observed a member of staff supporting a person in a toilet off a lounge/dining area. The door was not shut, and the person's privacy was not respected. People sat with soiled clothing protectors on for a long time after finishing meals.

● We found people's personal information was on display on signs and notices on the wall.

● Whilst staff were kind and caring in their interactions with people we found a lack of discretion at times. For example, a staff member spoke about different people's health conditions in a room full of people.

● We observed that tasks were not always carried out in private. For example, one person's blood sugar monitoring he lounge in front of other people and people were having their hair cut in a public area. People were not asked if they wanted this doing somewhere more private.

● Assumptions were made about people's wants and wishes. For example, one person was on an 'as required' medicine. We observed the person was not asked if they wanted this. When this was queried with staff they told us that the person always wanted the medicine. They then asked the person if they required the medicine and the person said they did not. This increased the risk of the person receiving medicines unnecessarily.

● One staff member told us, "We don't really have the spare staff to take residents out locally, but we can always get them something if they need it." This meant that people were not able to access the community if they wished to do so.

The provider failed to ensure people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

● We identified some very kind and patient interactions between people and staff however, staffing levels meant they were limited in what they could achieve with people.

● One person told us, "The staff are all very kind to me and we enjoy a bit of banter which I like, so I have absolutely no complaints about them."

● Relatives told us they were made welcome. One relative said, "The family are so grateful [person] is now safe and settled."

● We saw example of staff promoting people's independence where possible. One person told us, "The staff encourage me to walk when I can."

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.
Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- At our last inspection we recommended the service seek advice and guidance from a reputable source about activities, occupation and stimulation for people living with dementia. At this inspection we found that there had been no improvement in this area and people were not given the option of participating in stimulating, meaningful activities.
- We found no evidence of activities taking place on the days of inspection. A very limited activities timetable was in place but this was not followed. One person said, "I don't know of any activities here." A staff member told us, "Staff are too busy to do many activities with people."
- People did not get to regular access the local community. One staff member told us, "We don't really have the spare staff to take residents out locally but we can always get them something if they need it." This meant that people were not able to go out into the community if they wished to do so.
- Plans of care were not person-centred. They did not adequately detail people's wishes or preferences in this area and did not document outcomes and goals for people.

The provider had failed to ensure the care and treatment of people met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The registered manager told us that information would be sourced on an individual basis for people as they needed it in line with their needs. We were not provided with examples of how this had been done. We saw no examples in the home.
- Handovers took place on each shift change. A handover sheet was completed and a communication book was in place to help ensure people had up to date information on people's needs.

Improving care quality in response to complaints or concerns

- The registered manager told us that no complaints had been received since 2010.
- The service's complaints policy required updating as it contained out of date information.

End of life care and support

- At the time of this inspection no one was receiving end of life care.
- People's basic end of life wishes were documented in their care plans.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection systems in place to assess, monitor and improve the quality and safety of the service were not effective. 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 was still in breach of regulation 17.

● The planning and delivery of care was not always safe. There was an ongoing lack of oversight of the service which put people at risk of harm. Following our first two days of inspection the registered manager gave us assurances that a number of urgent concerns would be would be completed by a set date. This included addressing serious concerns with the management of risks around people's fluids and food, staff recruitment checks and use of unsafe equipment. When we returned to the service on the third day of inspection the majority of these issues had not been addressed.
●The premises and equipment were not maintained as legally required. This increased the risk of injury to people and staff. For example, we observed a person was being moved using a worn and frayed sling. When we returned for our third day of inspection the sling was still in use despite having been drawn to the registered managers attention.
●The provider's inadequate fire safety arrangements placed people at risk of harm in the event of fire. We contacted the fire service who visited and have issued an enforcement notice. This was due to them identifying a number of requirements that the service has to comply within a set time scale.
● Record keeping was poor across the service. Documentation relating to people's care and support was not completed fully with gaps in recording including food and fluid monitoring. There was no evidence in care plans viewed of managerial oversight. The issues we found on inspection with care planning had not been identified through auditing processes.

Due to poor governance of the service people were put at risk of harm. The provider failed to assess, monitor and mitigate risks to people and others. Accurate, up to date records were not kept for each person using the service. 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 failed to demonstrate their skills and competency to manage the service well for people. This is demonstrated by multiple breaches of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People were put at risk of harm as the registered manager did not demonstrate they had the required skills and competency to manage the service effectively and safely. This was a breach of Regulation 7 (Requirements relating to registered managers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure notifications were made to CQC and other bodies in line with legal requirements.

The provider failed to inform the Care Quality Commission without delay of notifiable incidents. This was a breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care
● The provider failed to ensure issues highlighted in previous inspections were addressed, such as window safety. The registered manager told us they had an improvement and refurbishment plan for the service, but this was not made available to us at the time of inspection.
● Provider audits had not identified a number of serious risks within the building. The registered manager told us many of the checks they made were visual. There were limited recordings to show audits had taken place.
● Actions from external audits had not always been acted upon. For example, an infection prevention and control audit by the local Clinical Commissioning Group recommended a legionella risk assessment was carried out in August 2017. This had not been undertaken. This increased the risk legionella bacteria could develop undetected within the building causing harm to people.
● There was no evidence that the registered manager gathered and used information in the day to day delivery of the service such as care plan reviews, resident meetings, safeguarding incidents, accident and incident data to learn and improve the care provided to people.
● Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements. The registered manager was unable to demonstrate a commitment to continual improvement and was not keeping up to date with current best practice guidance. Policies we looked at contained out of date information.

The provider failed to assess, monitor and improve the quality and safety of the service provided. This was 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
● The provider failed to ensure feedback was gathered from people, relatives and friends, staff and other professionals.
● We found no meaningful evidence that surveys or other methods were being used to gather the views of people's and others. There was no analysis of people's views or evidence of how feedback had been acted upon.

The provider failed to seek and act upon feedback from people, staff and other professionals. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● A range of information requested from the registered manager was either not provided, provided but not in a timely way or was insufficient to show how regulations were being met.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff gave mixed views of the management of the service. Some staff said they felt supported whilst others did not.

● Some professionals working with the service had concerns about the management of the service. They told us they felt that staff did not have the autonomy they needed to make decisions about people's wellbeing. For example, before ringing for emergency medical services care staff had to check first with the registered manager, even if they were not on site. This could delay someone getting the medical care they needed.

Working in partnership with others

● A number of professionals expressed their concerns about the management of the service.

● There was evidence of the service making referrals and working in partnership with some other agencies. However, not all referrals had been made in a timely manner.

● Relatives told us the service worked in partnership with other agencies to manage people's needs. One relative told us, "They [the service] organise everything here, the opticians, dentist, chiropody."