C&V Orchard Residential Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook this unannounced focused inspection of C&V Residential Limited on 08 January 2018. This inspection was prompted in part by information shared with CQC about the potential concerns around the management of people's care needs and a number of notifications received about people sustaining injuries at the home. This inspection examined those risks. Prior to this inspection we carried out an unannounced focussed inspection of this service on 08 November 2017. Breaches of legal requirements were found and we took the decision to use our enforcement powers. We will report on this once it is complete. Previous to this we completed a comprehensive inspection of this service in September 2017. Following this inspection we used are urgent enforcement powers and restricted admissions into the home and imposed conditions on the provider's registration. We required people's risk assessments to be updated and reflective of people's needs along with assuring adequate numbers of qualified trained staff were deployed effectively across the home. This was because people were at risk of harm. At this inspection we found the provider continued to not meet the requirements of the law and sufficient improvements have not been made.

At this inspection the team inspected the service against two of the five questions we ask about services: Is the service well led and is the service safe. This is because the service was not meeting some legal requirements. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

At our September 2017 inspection we gave the location a rating of 'inadequate' and entered it into special measures. We identified seven breaches of the Health and Social Care Act (HSCA) 2008 and one breach of the Care Quality Commission (Registration) 2009. At this inspection we found the provider continued to be in breach of the HSCA regulations. You can see what action we told the provider to take at the back of the full version of the report.

C & V Residential Limited 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 care home accommodates people in one adapted building. C & V Residential Limited accommodates 32 people, some were living with dementia. At the time of the inspection there were 22 people living at the home.

The home currently has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not have their needs met in a timely manner because there were not enough staff nor were they effectively deployed across the home. Staff did not have the skills and knowledge to meet people's needs effectively. People were not protected from the risk of harm because staff did not understand how to

manage people's individual risks to keep them safe. People did not always receive their medicines as prescribed and people's nutritional needs were not always being met. The recruitment system operated by the provider needed to be improved to ensure staff were suitable to work with the people living at the home.

Staff had not received adequate training nor had their competencies checked to ensure care provided to people was safe and effective. The care people received was not always responsive to their own individual needs. People had mixed views about whether the service was well led. People were not protected by a quality assurance system that identified areas of improvement needed to ensure people received safe effective care. The provider continued to fail to recognise and improve the quality of care being provided to people. Staff did not have effective leadership which meant people were not protected from risks to their health, safety and well-being.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and safety were not managed. There were insufficient numbers of skilled staff to meet people's needs. People did not receive their care in a timely manner. Opportunities were missed to learn lessons from accidents and incidents. Recruitment processes in place could not assure people were supported by staff that were competent and well trained in their role. People did not always receive their medicines as prescribed. People were protected from the risks of infection.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected by effective quality assurance systems. Systems in place did not provide staff with the means to do their job effectively. Care records did not reflect people's needs. People were unclear who was in charge of the home on a daily basis and staff were unclear about the leadership in the service. People did not always have their views sought and feedback had not been used to make improvements in the quality of service provided.

C & V Orchard Residential Limited

Detailed findings

Background to this inspection

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

The inspection was prompted due to potential concerns about the management of risk and staffing levels at the home. We decided to complete a focused inspection. This inspection examined those risks.

This inspection took place on 08 January 2018 and was unannounced. The inspection team consisted of two inspectors.

As part of the inspection, we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We also asked for feedback from the commissioners of people's care to find out their views about the quality of the service. We also contacted the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

During the inspection, we spoke with four people who lived at the home and three visitors or family members. We spoke with the registered manager, the provider and an external consultant. We also spoke to eight members of staff. We carried out observations throughout the home to help us better understand the experiences of people living at the home to review the quality of care people received. 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 looked at four care records for people. We also looked at other records relating to the management of the service including staff files, accident reports, audit records and four medicine administration records.

Inadequate

Is the service safe?

Our findings

At our inspections in September 2017 and November 2017; we found the provider did not meet the requirements of the law. We found the service was not safe and we rated the provider as 'Inadequate' in this key question. Risks to people were not sufficiently managed to reduce the possibility of harm. We found there was not enough staff deployed to meet people's needs and people were not always protected from the risk of harm or abuse. Following the September 2017 inspection we restricted admissions into the home and imposed conditions to ensure staff knew people's individual risks and the care records were reflective of people's current needs. We also required sufficient numbers of suitably skilled and experienced staff be deployed at all times. Following the November 2017 inspection. We commenced additional enforcement action and will report on this when it is complete. At this inspection we found the provider had failed to make sufficient improvements and continued to breach the requirements of the law, placing people at ongoing risk of unsafe or inappropriate care.

At our previous two inspections we saw one member of staff remained in the communal lounge area so that they were able to respond to people's requests. We saw this was not sufficient because people waited for periods up to twenty minutes for their care needs to be met. Some people told us they experienced pain because they had to wait for their personal care needs to be met. This information was shared with the provider following the inspections and they assured us improvements would be made to make sure people's needs were responded to in a timely manner.

At this inspection we found people continued to tell us they had to wait for staff to respond to their care needs. One person said, "I have to wait for my needs to be met as staff are so busy with other people." We saw one person waited in excess of thirty minutes for their personal care needs to be responded to and they told us they were feeling uncomfortable. A member of the inspection team intervened and requested a member of staff support them with their personal care. Staff told us some people had to wait for their needs to be met as they required two members of staff to support them. They said this proved difficult to manage at times because they needed to ensure a member of staff remained in the lounge area at all times. One member of staff said, "I don't think there are enough staff to meet people's needs. Its chaotic here, there is no flexibility with duties and you don't have time to sit and talk to people." They continued, "You need two staff in the lounge to meet people's needs, one staff member is not enough and people have to wait."

At our previous two inspections we observed staff prevented people from moving freely around the home. We saw people being told to 'sit down' by members of staff. At this inspection we continued to see people's movements being restricted. We saw two people attempted to mobilise independently; these people were at high risk of falls. We saw staff restricted their movement by holding their walking equipment and blocking their path. Staff told us some people regularly tried to mobilise in order to leave the room but said they were unable to respond to their requests as there was not a sufficient number of staff available.

At our inspections in June 2016, May 2017 and September 2017 we asked the provider how they determined the number of staff required to meet people's needs. We were told by the registered manager and provider that people's dependency levels would be reviewed and a system implemented to determine the number of

staff and skill mix required to meet people's needs. At our November 2017 inspection we found a system had been developed to determine people's dependency needs. However, we found it was not effective because it did not take account of people's current care needs nor did it determine how many staff were required and what skills would be required to meet those needs. This meant people were not protected from the potential risk of harm because there was insufficient staff deployed to keep people safe.

At this inspection we found the concerns identified at our last inspections had not been addressed and the provider had failed to determine safe staffing levels based on people's needs. One member of staff told us, "At night there are [three] care staff. It would be better with a senior because if people need painkillers only the senior can access these." The provider and registered manager told us they operated an 'on call' system at night which meant senior staff could be contacted and they would come to the home if people required medicines such as pain killers. We asked to see the system developed to determine people's dependency needs. The registered manager and provider were not able to find this information. Conversations with the registered manager and provider about people's needs and the number of staff required to meet those needs indicated that the deployment and skill mix of staff had not been reviewed since our last inspection. We also found there was no effective system in place to maintain adequate staff numbers when staff were off sick or on annual leave. As a result people had been put at risk due to inadequate staffing levels. We looked at four care records and found these had not been updated following changes in people's dependency needs. For example, after discharge from hospital or incidents. People required additional support from staff and this had not been considered by the provider. We found people's needs continued not to be met effectively and they remained exposed to the risk of harm due to the inadequate deployment and insufficient numbers of staff.

This is a continued breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

At our previous two inspections risks to people's safety were not managed effectively to protect people from the risk of avoidable harm and we took enforcement action against the provider. At this inspection we found sufficient action had not been taken to protect people from the risk of harm and people remained at risk of unsafe or inappropriate care. Staff and the registered manager told us how they managed people's risks; however, we saw they did not consistently provide care to people in the way they explained to us.

One person was at high risk of falls and had recently been discharged form hospital. Although the provider had carried out an assessment of the person's needs we did not find anything in place when we carried out our inspection. Staff we spoke with explained how they supported this person's needs. We looked at this person's care records and found it did not correspond to the way staff had told us they delivered care. We found there were not clear instructions on how staff should support this person's mobility safely. In addition to this we saw the planned support required for this person following discharge from hospital was not provided. The person required prompting and guidance by two members of staff at all times in relation to their mobility. We saw this planned support was not provided and as a result this person was at an increased risk of falling.

Another person required repositioning regularly using equipment to maintain their skin integrity. And protect them from the risk of developing pressure sores. We observed this person throughout the day of our inspection and found repositioning did not occur. We looked at this person's care records and saw their hospital discharge letter stated the person had pressure areas which needed to be monitored. We spoke with the registered manager and staff about how the person's care needs were being met. Conversations with staff and the registered manager conflicted to what we saw. Staff and the registered manager were not able to confirm whether the person had pressure areas and how these were being managed. Furthermore

the registered manager was unable to produce records to demonstrate that pressure areas and wounds when present were monitored and assessed. The registered manager later told us staff were unsure how this person should be repositioned. This meant the person was at an increased risk of harm as staff did not understand their risks and how to effectively manage them.

One person had sustained significant weight loss and was at an increased risk of malnutrition. No action had been taken to address this. We could see evidence of a dietician's visit on 13 December 2017 and that they had recommended a high protein, high calorie diet with nutritional supplements three times a day. We asked staff and the registered manager about this. Staff told us they were not aware the person's nutritional supplement had increased. We spoke to the registered manager about our concerns who told us they would contact the doctor to obtain the person's prescription in order for them to receive the additional supplement. We asked to see the fluid and food charts for this person however these were not available during our inspection. Staff were not able to accurately monitor the person's nutritional intake to ensure they were having sufficient to eat and drink. The registered manager had not ensured people's risks of weight loss were managed in a safe way.

Furthermore three people required their fluids to be thickened to reduce the risk of them choking. Although staff were aware these people were at an increased risk of choking; staff were unable to give us consistent answers about the quantity of thickener needed to ensure drinks were of the correct consistency. We saw one person coughing whilst they were drinking a thickened drink. Staff intervened and asked the person to 'slow down'. We looked at the care record for this person and found there was not a care plan or risk assessment in place for staff to refer to about how to prepare their drinks or how many scoops of thickener should be used. We also found staff were using one person's prescribed thickener to prepare all thickened drinks. We asked staff and the registered manager about this; It was unclear from our conversation how this had occurred. The registered manager said they would address this and ensure people received their medicine as prescribed. The registered manager had not ensured people at risk of choking needs were assessed and managed.

At our previous inspection we identified concerns in relation to people's Personal Emergency Evacuation Plans (PEEPS). These are important individual 'escape plans ' for people who may not be able to reach a place of safety unaided or within a satisfactory period of time in the event of any emergency. We found these were still not up to date and were not reflective of people's current mobility needs and requirements should they need to exit the building in an emergency. At this inspection we found the concerns identified at our last inspection had not been addressed. During our conversations with staff we found not all staff were aware of the evacuation procedures in the event of an emergency. This meant people were at risk of a delayed or unsafe evacuation from the building in the event of an emergency because staff did not know how this should be carried out. Following the inspection we contacted the Fire Service and made a referral for a fire safety inspection to be completed.

At our previous two inspections we found people were at risk of harm. This was because staff did not understand people's specific risks and how to manage them. At this inspection we found staff continued to have inconsistent and inadequate knowledge of people's risks and what action to take to keep people safe. We found the concerns identified at our last inspection had not been addressed. Staff we spoke with explained they had not received any guidance nor had they received training in relation to supporting people who may display behaviour that could challenge. As a result they did not have a consistent approach when supporting people. For example, one person might display particular behaviours when they required personal care. Staff we spoke with gave inconsistent responses about how they would support this person's needs. We looked at the person's care record and found information about how to support them was not reflective of their needs. Without the correct written guidance available, people could be at risk of

not receiving the right care or support.

At our previous inspection we found there were a number of incidents recorded where people had fallen, had unexplained bruising or had a skin tear. We found no evidence to demonstrate that those incidents had been investigated, lessons had been learnt or that preventative measures were put in place to reduce the risk of reoccurrence or harm. At this inspection we continued to find the concerns identified at our last inspection had not been addressed and as a result we could not be assured accident and incidents to people were effectively managed. For example, one person had fallen on two occasions and sustained injuries; we found no evidence these injuries had been investigated. We also found although incidents were recorded staff and managers were not monitoring incidents that arose due to particular behaviours. As a result potential 'triggers' had not been identified or ways in which staff might decrease the risk of reoccurrence in order to reduce the risk of harm to themselves or others.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

At our previous two inspections we found although people told us they felt safe; we found incidents of potential harm or abuse had not been recognised by staff. This had resulted in safeguarding concerns such as unexplained bruising not being referred to the local authority or investigated. At this inspection people told us they felt safe with the care they received. One person said, "I have no worries, I feel safe living here the staff are good." Staff told us they were aware of the signs of suspected abuse and knew how to protect people. One member of staff told us, "I would tell the senior if I thought someone was being harmed." Another member of staff told us they had not received training about how to protect people from harm. However, explained to us the different types of abuse and said they would report any concerns they had to the senior carer or the management team. They continued to say they would contact the local authority or CQC if they did not think concerns were being dealt with appropriately.

At our previous two inspections we found the management team did not have sufficient knowledge of how to recognise or report safeguarding concerns to ensure people would be sufficiently protected from potential abuse. They did not recognise some incidents that had occurred in the home as possible safeguarding and had not taken any action to mitigate the risk of reoccurrence. As a result, the provider had not protected people from potential abuse or improper treatment. At this inspection we found the registered manager had made referrals to the local safeguarding authority when they suspected any form of abuse may have taken place. This meant people were protected from harm because staff knew how to recognise the signs of abuse and what to do should they suspect abuse had taken place and the registered manager had a system in place to report safeguarding concerns to the local authority.

We looked at how medicines were managed, which included checking the medicine administration record (MAR) charts for four people, speaking to senior care staff and reviewing how medicines were stored. One person said, "I don't have any problems with my medicines I get them when I need them." Although people told us they got their medicines, we found some people did not always get their medicines as prescribed because they were not available. For example, nutritional supplements and thickener. We looked at how medicines were ordered, stored and audited to ensure people had sufficient medicines for their health needs. We found audits had not been completed since our last inspection and as a result issues we found at this inspection were not known.

People told us they received their medicines on time. We observed staff supporting people to have their medicines and talking to them. Staff told us that systems were in place to ensure the correct amount of time had lapsed before the next medicine was given and we saw evidence of this. For example, one person

required their medicines to be given at specific times we saw this was adhered to. However we saw the planned medicine round at 16.00hrs was not completed. This was because staff did not have the time to check in new medicine stock before the next medicine round was due. This resulted in a delay of one hour for people receiving their medicines.

We looked at the MARs and noted that these had been completed accurately and the amount of medicine administered matched what had been recorded. Some medicines were to be given on an 'as required' basis we saw there was guidance in place for staff to refer to and to inform them of the circumstances in which they should be administered. We looked at how medicines were stored and unwanted medicines disposed of and found medicines were stored securely and unwanted medicines returned to the pharmacy for disposal.

We looked at how the provider ensured members of staff were recruited safely. Staff told us that prior to commencing in post, they were required to provide references and complete a check with the disclosure and barring service (DBS). The DBS check would show if a prospective employee had a criminal record or had been barred from working with adults. However we found the provider had failed to complete suitable recruitment checks for those staff that had transferred to C & V Residential Limited from another home operated under a separate legal entity. We also looked at the disciplinary processes used by the provider. We were not assured concerns raised about staff members had been adequately addressed. For example, we found a person living at the home had raised a concern about a member of staff; we could find no evidence this concern had been investigated. This meant people were not always protected from the risk of harm because the recruitment and disciplinary systems operated by the provider were not effective.

We looked at the cleanliness and hygiene of the home. People told us they found the environment clean. One person told us, "My room is very clean and tidy." At our last inspection we found in some communal corridors and bedrooms unpleasant odours were present. We saw domestic staff worked at the home whose responsibilities were to ensure people's bed-rooms, communal areas and bathrooms were cleaned and we saw checks were completed of all the rooms daily. Since our last inspection the provider had started a programme of refurbishment and had replaced the communal lounge carpet and had also replaced the dining tables. We completed a visual check of the environment and found the bathrooms contained soap, hand towels and clinical waste bins along with hand washing instructions for staff to follow. Around the home aprons and gloves were available for staff to use when providing care. We looked at the laundry and found it was organised and had a system in place to prevent cross infection from dirty to clean laundered clothes. We also looked at food hygiene and found the fridge and freezer were checked daily and temperatures checked to ensure food was stored appropriately. We also observed the kitchen area was regularly cleaned to ensure the area was suitable to prepare food. Adequate measures were in place to protect people from the risk of infection.

Inadequate

Is the service well-led?

Our findings

At our inspections in September 2017 and November 2017; we found the provider did not meet the requirements of the law. This was because the provider's quality assurance systems were ineffective and risks to people were not sufficiently managed to reduce the possibility of harm. Following our September inspection, we used our urgent enforcement powers and put condition's on the provider's registration. After our November 2017 inspection we took further enforcement action and will report on this once it is complete.

At this inspection we found a continued failure to make the necessary improvements to quality assurance systems and an ongoing failure to ensure people's safety and well-being. The provider had failed to comply with the requirements of the law.

We looked at the systems the provider used to monitor the quality and safety of the service. At our previous two inspections we found people's health and well-being were not sufficiently protected This was because effective systems and processes had not been implemented to ensure people received care and support when they needed it and to keep them safe At this inspection we found the concerns identified at our previous two inspection's had not been addressed. We found both the provider and registered manager had failed to develop a quality assurance system which was effective. Insufficient improvements had been made in the governance systems and people continued to be at significant risk of harm due to inadequate oversight of the safety and quality of support they received. For example, some people's needs had changed following discharge from hospital; one person required regular repositioning and a number of incidents had occurred to people such as skin tears. We found staff's knowledge of people's risks were inconsistent and as a result people did not always receive the care and support required to keep them safe. The management team had failed to recognise and respond to these issues because of the inadequate governance systems.

We found there were not effective communication systems in place. Conversations with staff indicated the system used at shift handover was not effective. Staff were not knowledgeable of people whose care needs had recently changed and of incidents that had occurred within the home. Furthermore we found inadequate systems were in place to identify learning from incidents which would mitigate future risks to people and reduce the possibility of accidents reoccurring. At our last inspection it was found there was no overarching system in place to review patterns, identify trends or factors in incidents to show if any changes needed to be made to people's care. At this inspection we found our concerns had not been addressed. The provider had failed to implement effective systems which addressed these issues.

At our last inspection staffing levels had been increased by one member of staff on each shift and a dependency tool had also been developed detailing people's individual needs. However, we found people continued to wait for prolonged periods of time for their needs to be met and the provider had not recognised this. At this inspection we found the concern identified in relation to staffing levels and the deployment of staff had not been rectified. Staffing levels remained insufficent and we found no evidence that people's dependency levels had been reviewed. As a result people continued to experience delays in receiving their care along with their movements being restricted. The provider and registered manager were

unaware of the challenges the staff faced in relation to meeting people's needs in a timely manner. They failed to ensure there were systems in place to determine the number of staff required and the skills required to meet people's needs. Furthermore they did not consider the changing needs of people and as a result failed to ensure sufficient staffing levels and skill mix to meet the needs of the people living at the home. As a result people remained at risk of unsafe or inappropriate care because the staffing issues had not been addressed.

At our previous two inspections we looked at the systems used to ensure staff had the skills, knowledge and training to meet people's needs. We found the provider and registered manager had failed to develop and implement effective systems to evaluate staff practice. At this inspection we found these concerns had not been addressed. Staff told us they understood what their responsibilities were however said they did not always receive sufficient guidance from the management team nor had they received training to provide care to people safely. For example, people living with dementia. We looked at the provider's systems to monitor staff competencies in particular in relation to moving and handling, supporting people with dementia and medicine administration. We found that staff training and supervision was not consistently provided to all staff to ensure they supported people safely and effectively. Furthermore we found not all staff had completed moving and handling training nor had their competency been assessed to ensure they were supporting people safely. We found where there were concerns regarding staff competency levels these had not been addressed. For example moving and handling techniques. Throughout our inspection we saw people were exposed to the risk of injury due to unsafe moving and handling practices. Staff we spoke with gave us inconsistent answers about how one person should be moved to protect their skin integrity. We also saw throughout the day staff did not check equipment was secure before mobilising people. This increased the risk of people sustaining an injury. The provider and registered manager had continuously failed to take sufficient action to address these concerns.

We did not see any evidence of audits being completed since our last inspection and this had resulted in some people not receiving the support they required. The registered manager and provider had failed to identify care records and risk assessments were not up to date and did not reflect people's current care needs. We found ineffective monitoring and review of people's needs and risk associated with pressure care and weight loss. We also found recommendations which had been given by healthcare professionals had not been acted upon in a timely manner.
We found medicines had not been audited and as a result the discrepancies which we found had not been identified from the provider's own systems. Systems to ensure staff were recruited safely were not effective nor were there processes in place to ensure adequate staffing levels when staff were off sick or on annual leave.

At our previous two inspections we identified significant shortfalls in the leadership and management of the home. At this inspection people were not always aware of who was running the home as a number of changes had recently taken place and they had not been informed. At our previous two inspections people told us their views were sought about the quality of service they received but they could not recall having any feedback. At this inspection we found this had not been addressed. We spoke to the management team about this and were informed a meeting had been arranged for families. The management team acknowledged that opportunities had not occurred recently for people to feedback about the quality of the service and they were looking to address this. We found there were systems in place for visitors and staff to raise concerns by the use of a comment box along with questionnaires. The systems in place did not ensure that any feedback received was analysed to identify issues or areas for improvement. This showed us although views were sought; they were not used to improve the quality of the service.

At this inspection the provider told us they had employed a consultant to work with them to improve the

quality of service people received. We spoke with the consultant who told us their main focus was to ensure the service improved so the care people received met their needs and was safe. They told us since they had started to work at the home they had implemented a number of changes for example moving the office to the ground floor so they were more visible to people, visitors and staff; introducing weekly staff meetings and reviewing people's care records. The provider also told us the management structure was under review. Staff we spoke with told us they were unsure of the current management arrangements in the home and said they did not feel supported in their roles. They said they received little guidance from the management team and said support was provided by the senior carer on duty. The senior carer would allocate tasks to staff along with providing guidance. Staff we spoke with had a mixed understanding of whistle –blowing but said they would report concerns to the senior carer or provider. Whistle-blowing means raising a concern about a possible wrongdoing within an organisation. At this inspection we found the leadership continued to be weak and the provider and management team continued not to have an oversight of the home, or of how staff delivered care to people. We found the improvements required had not been implemented or embedded and as a result people did not receive a good standard of care.

We found the management team and provider continued to fail to take responsibility for the failings of the service and the continued regulatory breaches. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

At our previous inspections we found the provider failed to notify CQC about significant events as required by the law and as a result was in breach of Regulation 18 Care Quality Commission (Registration) 2009. Prior to this inspection we reviewed the information we held about serious incidents and safeguarding's within the home. Since our last inspection the provider has implemented a process and was now submitting notifications to the CQC as required by law. Registered providers are also legally required to display the ratings awarded by CQC we noted this information was visible in the reception area of the home.

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 ensured risks to the health and safety of people were assessed and managed so they were in receipt of safe care and treatment. The provider had not ensured they had done all that is reasonably practicable to mitigate such risks.

The enforcement action we took:

Urgent action has been taken to restrict admissions and impose positive conditions on the provider's registration. We have also served a proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services provided. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service who may be at risk.

The enforcement action we took:

Urgent action has been taken to restrict admissions and impose positive conditions on the provider's registration. We have also served a proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent skilled and experienced staff deployed.

The enforcement action we took:

Urgent action has been taken to restrict admissions and impose positive conditions on the provider's registration. We have also served a proposal to cancel the providers registration.