SNSB Limited

Roop Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Roop Cottage is a care home providing residential care to up to 35 people. At the time of the inspection there were 19 people living in the home.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support: People's choice and independence were not maximised. Where people had a learning disability, there was no engagement with them about where or how they would like to spend their time.

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

Right Care: Care was not person-centred and did not promote people's dignity or human rights.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people were leading confident, inclusive or empowered lives. Leadership and management was not robust. There was a high turnover of managers and the manager appointed since the last inspection was no longer working in the home.

Risks to people had not been assessed or addressed and there was little evidence of lessons learned from previous inspections. People had been received into the service without adequate assessment of their risks or care needs. There was limited evidence of action taken to address care and safety concerns raised with the provider since they took over this home. These issues included: leadership in the home, systems to ensure the safe management of medicines, person centred care, risks in the environment, and safe recruitment.

Mealtimes were based around staff availability and not personalised to the times when people preferred them. People were not always supported to have a drink until breakfast after 9am, although many people were awake much earlier. There had been a continuous lack of action from the provider to resolve this since they took over the service in 2021. People's dietary needs were not safely managed to mitigate risks in relation to malnutrition, dehydration, choking and diabetes.
Staff had received some training, but this was not sufficient to meet the needs of people being cared for at

Roop Cottage. No staff had completed training to support people with a learning disability and only 1 member of staff had completed dementia awareness training.

Care provision was not managed around people's needs and preferences. Some people were not supported to come out of their rooms and there was a lack of meaningful activity. There was disregard for people's privacy, dignity and independence. Recording of people's care and needs lacked detail and was of poor quality.
Some staff knew people well and had established caring relationships with them. Staff interaction was kind and patient when carrying out care tasks.

At our last inspection of the responsive key question, we recommended that the provider works with relevant partners to ensure staff receive suitable training in end of life care and support, and people have well developed care plans in this area. At this inspection, this recommendation had not been acted upon. No staff had received any training for end of life care and care plans were not reflective of people's wishes.

During feedback following the inspection, the provider showed us some developing systems and processes, intended to make the management of the service more robust. However, these were in the early stages of development and not yet implemented.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 11 August 2023). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted due to concerns received about people being unkempt and remaining in their rooms, poor management of choke risks, dietary needs, weight loss, diabetes, pressure care, privacy, dignity and cleanliness of the environment. A decision was made for us to inspect and examine those risks.

A decision was made for us to inspect and examine those risks.
We inspected and found there was a concern with person-centred care, so we widened the scope of the inspection to look at all 5 key questions, which included; safe, effective, caring, responsive and well-led.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

We have identified breaches in relation to person centred care, privacy and dignity, people's safety, safe recruitment, staff training and management of the service 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

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 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? 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 caring Details are in our caring findings below	**Inadequate**
Is the service responsive? The service was not responsive Details are in our responsive findings below	**Inadequate**
Is the service well-led? The service was not well-led Details are in our well-led findings below	**Inadequate**

Roop Cottage Residential 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.

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
This inspection was carried out over 2 days by 2 inspectors. An Expert by Experience also attended on the first day. 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
Roop Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
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 reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with 8 people who lived in the home and 2 relatives. We spoke with 9 staff, as well as the acting manager and the regional manager. We also spoke with a visiting professional. We reviewed a range of records. This included 5 people's care records, plus additional care plans for specific information, as well as medication records. We looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider in support of the inspection.

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 the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Risks to people were not sufficiently assessed, monitored or mitigated.
• People were accepted into the service, without assessments of the risks to themselves or others. There was insufficient equipment available to meet people's needs safely. Call bells were not in place or in reach. There were no adequate checks or testing of call bells.
• Staff knowledge around people's individual care risks was variable, particularly in relation to their dietary needs such as choking, weight loss and diabetes.
• People were not weighed consistently and records were poor. Where there were recorded weight losses, no action had been taken to follow up on this.
• There were hazards in the environment which had not been addressed. The kitchen area and the door from the kitchen to outside were not secured, in spite of the door having a secure keypad and having been raised as a concern at previous inspections.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people were not assessed, monitored or mitigated.

Learning lessons when things go wrong
• There was very little evidence to show opportunities for learning were identified when things went wrong.
•There was insufficient oversight, such as of accidents and incidents, to identify where lessons could be learned.
• Concerns raised at previous inspections of the service were not sufficiently acted upon.
•The provider repeatedly accepted new people into the service without assessing risk, even though a serious incident had occurred with one new person who was admitted without assessment of the risks to themselves or others. This demonstrated lessons had not been learned.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were no systems and processes to identify risks, opportunities for

learning or action taken to prevent further occurrences.

Staffing and recruitment

At our last inspection, the provider had failed to ensure robust recruitment procedures were followed to confirm staff were safe to work in the service. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19

• Safe recruitment procedures were not robustly followed.
• For 2 staff appointed, there was no evidence to show references were valid or authentic. References were obtained by the staff themselves prior to application and were addressed 'to whom it may concern', but there was no evidence the provider had contacted the referees.
• One member of staff was interviewed 6 months after their application, and appointed 10 months after their interview, with no evidence to ensure all background checks were current at the point of employment.
• Interview records were sparsely completed.
• There was no record to show how the manager, who was no longer working in the service, had been recruited.

This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as robust recruitment procedures were not followed.

Using medicines safely

At our last inspection, the provider had failed to ensure the safe and proper use of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Systems and processes were not in place to ensure the safe management of medicines.
• Recording of medicines and guidance for staff was not robust or in line with safe practice. Some medicines administration records (MARs) did not have a photograph to identify the person safely. Some PRN protocols (to guide staff on the use of 'as required' medicines) were not in place or were unclear.
• Nutritional supplements for people at risk of losing weight were not sufficiently given to people as prescribed.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to manage medicines were not robust.

• The provider had taken steps to ensure night staff on duty were trained to support people with administering their medicines. This had been a concern at the last inspection.

Preventing and controlling infection

At our last inspection, the provider had failed to implement systems to assess, prevent and control the spread of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Infection prevention and control measures were not robustly in place.
• Some people had dirty teeth, mouths and fingernails, posing a risk of infection.
• Some equipment was not thoroughly cleaned and there was a build-up of dirt, debris and stains, such as on furniture, and around taps in bathrooms. The hand wash sink in the upstairs medicines room was not clean.
• The dirty laundry trolley was left in a corridor and one person was handling soiled items; we alerted staff to this infection control risk.
• Some malodours were present in areas of the home. Some soap dispensers were empty.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to prevent and control the spread of infection were not robust.

• Cleaning staff were on duty and attended to routine cleaning duties.

Visiting in care homes
• Visitors were welcome to see their family and friends at any time.

Systems and processes to safeguard people from the risk of abuse
• People were not robustly safeguarded from potential abuse or harm.
• Not all staff understood how to identify safeguarding concerns or what to do if they thought a person was at risk of harm.
• There was no oversight of accidents and incidents to enable possible safeguarding concerns to be identified and acted upon.
• Staff had completed online safeguarding training.
• People and their relatives told us they felt safe living at the home.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At the last inspection, the provider had failed to ensure staff had the appropriate support, training, professional development and supervision for their role. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 18.

• The provider's statement of purpose stated Roop Cottage cared for people living with a learning disability, older people, younger adults, mental health, physical disability, sensory impairment and dementia. Staff had not received training to meet the needs of people living in the home.
• Staff were not trained to support people with autism or a learning disability. Only 1 member of staff had received training in dementia awareness. No staff had received training in nutrition and hydration, and only 2 staff had completed training in mental capacity. No staff had completed training in oral health and hygiene.

This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not supported by staff trained to understand their needs.

• The provider had taken steps to ensure all senior staff, including night staff were trained to support people with medicines.
• The provider had scheduled supervision meetings with staff.
• Some staff said they felt they had enough training and support to carry out their work.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; adapting service, design, decoration to meet people's needs
• People's care and support needs were not assessed to enable up-to-date care plans to be written to show how their needs and choices would be met.
• At the last inspection, some people remained in bed or in their rooms. This was again a concern raised at this inspection, with no evidence this had been addressed, in spite of assurances previously given by the provider.
• Resources with which to support the needs of people living with dementia remained limited. No improvements were made to the lounge area to encourage social interaction.

• Assessments and care plans lacked detail for some people. We reviewed care records for 5 people who were newly accepted to the home. Their care needs had not been identified or assessed. The acting manager told us care plans were in the process of being updated to electronic format and improvements were in progress. However, this was identified as a concern at the last inspection and we had been given assurance of improvements previously.

Supporting people to eat and drink enough to maintain a balanced diet
• People were not always supported to have enough to eat and drink, and in line with their individual needs.
• As at the last inspection, there was limited evidence of people having been supported with a drink first thing in the morning. There were drinks positioned in the dining area, but these were not accessible to people who were not able to help themselves.
• At the last inspection, meals were served later than when people wanted them. Breakfast was not served until after 9am and some people had to wait for an hour to be served lunch. People told us they had to wait for breakfast and on both days of the inspection we heard some people called to staff to bring them a drink or breakfast. One relative told us, "If [name] wanted food early in the morning they will bring [them] a drink or cereal, but not hot food. Sometimes they don't get breakfast until ten or ten thirty."
• Staff told us they would support people with drinks when they asked for one. However, some people were unable to make their needs known verbally and they were not always adequately supported. Two people who were unable to speak with us had very dry mouths and one person was chewing their hand, which staff said was a sign they may be thirsty or hungry.
• The provider had given assurances following previous inspections, they would review practice around support for people to maintain a balanced diet in line with their needs, yet this had not been done.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure risks around people's nutrition and hydration were mitigated.

• People and relatives said the food was nice and the cook 'went the extra mile' to make sure they enjoyed what they were offered. One person said, "The food is nice and you get plenty" and another person said, "The best thing is the beautiful food." A relative said, "The meals are lovely."
• People were given visual choices of the food on offer.

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.

• Some people did not have an assessment of capacity, particularly those who had been admitted to the service with only limited care records.
• Some staff were unsure whether people had capacity to make their own decisions. Only 2 members of staff had completed training in mental capacity awareness.

• As at the last inspection, there was mixed practice in relation to people being supported to make decisions. Some people were not given choice around where or how they wanted to spend the day. Many people remained in their rooms, even when their preference was to be in communal areas.
• There were some legal authorisations to deprive people of their liberty where necessary, but records were not consistent or complete.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People received timely access to healthcare services where staff had knowledge of their needs.
• Care records contained evidence of referral to other professionals involved in people's care, such as community nurses, GPs and emergency medical professionals where necessary. Relatives told us staff were supportive of people's health appointments outside the home.

Inadequate

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 changed to inadequate This meant people were not treated with compassion and there were breaches of dignity.

Ensuring people are well treated and supported; respecting equality and diversity
• People were not always well treated or supported in line with their wishes.
• Support for people around waking times, drinks and mealtimes was not person-centred and did not respect people's preferences and wishes.
• Some people were supported to be washed and dressed before the end of the night shift, but then put back into bed. Care staff told us this practice had 'always happened'.
• People's personal care was not always promoted or carefully carried out. Some people had very dirty fingernails and one person's nails were sore and encrusted with dirt and debris.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people did not receive person-centred care around their day-to-day routines.

• Staff spoke with people in kind and caring ways. Some staff knew some of the people well and had established caring relationships with them and their families.
• People and relatives said staff had a caring approach. One person said, "I am well looked after. There isn't anything they wouldn't do for you." A relative said, "Some staff are lovely and will go the extra mile."

Respecting and promoting people's privacy, dignity and independence
• People's dignity and respect was not promoted.
• One person's bedroom window was directly adjacent to the conservatory area, used as a staff room, but also accessible to other people and relatives. The person's preference was to not wear clothes, however they could be seen from the conservatory. Although there were curtains at the window, these were too small, therefore the person's privacy was not maintained. People's privacy in relation to this room had been discussed with the regional manager on previous inspections, and they had assured us the room would not be used as a bedroom in future.
• People did not have adequate support to maintain their oral hygiene. Some people were without teeth cleaning equipment and we saw several people with visibly dirty teeth and mouths.
• One person had been supported to have a shave, but there were several shaving cuts to their face. There was nothing in the person's care record to show they wished to have a shave, or consider how this might be done with care and dignity.
• One person told us their independence was not encouraged. They said their wheelchair was used by staff to support other people [without their permission]. They said, "It would be nice to get up and go in the lounge to chat to other people. I would like to get up and go into the garden. The equipment is for me not

others and I could get up if I had it."

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's privacy and dignity was not regarded.

Supporting people to express their views and be involved in making decisions about their care
• People were not fully supported to express their views and be involved in decisions affecting their care and support.
• People told us they would like to spend more time out of their rooms, but were not supported for this to happen, particularly where they were not independently mobile. One person said, "I never come out of my room. They [staff] never offer to get me up."
• Two people's care records stated expressed wishes that they did not want to be isolated in their room. However, they remained in bed, and there was no evidence to show they had been supported with decision making around this.

Inadequate

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 requires improvement. The rating for this key question has changed to inadequate.
This meant services were not planned or delivered in ways that met people's needs.
Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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

• Care was not planned around people's individual needs, interests and preferences.
• Delivery of care, such as mealtimes and personal care, was arranged around staff rotas and routines, rather than being person-centred.
• Care plans were in the process of being transferred from paper to electronic records, and these were of variable detail and quality; some care plans were not in place at all, some information was conflicting and lacked accuracy and others were more detailed. One person arrived at the home without information and staff did not know anything about their needs or preferences.
• Where care plans were in place, people's care was not being delivered to ensure they had choice and control. There was little support for people to prevent social isolation and to engage with others. For example, 2 care records clearly stated these people wished to come out of their rooms during the day, but they remained in their rooms on both days of the inspection. At previous inspections, this matter had been raised with the provider, with assurances given for action.
• There were no activities during the inspection and only limited meaningful engagement. Some staff engaged with people for a short time as they watched music videos. However, there were only 4 people in the lounge area and they had been there for some time before staff joined in. Staff were attentive when speaking with people, but this was frequently confined to times of personal care delivery.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people did not receive person-centred care around their day-to-day routines.

End of life care and support

At the last inspection of this key question, we recommended the provider works with relevant partners to ensure staff receive suitable training and people have well developed care plans in this area. This recommendation had not been acted upon. No staff had received any training for end of life care.

• At the time of inspection, no one was in receipt of end of life care. Some care plans showed end of life care had been discussed, although this was a basic record of people's wishes.
• No staff had received any training for end of life 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.

• People's communication needs were not always documented within their care files.
• Staff communicated with people in a variety of different ways according to their needs. For example, by speaking slower and allowing time for people to respond.
• Some staff knew some people very well, particularly where they had been at the home for a number of years. As a result, they knew what people's non-verbal cues meant when they were unable to speak with them.

Improving care quality in response to complaints or concerns
• Complaints were recorded along with responses and kept on file.
• Some people and relatives knew how to complain if they were unhappy.
• People and relatives said they did not have any complaints, although some said they would like to see improvements.

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 inadequate. The rating for this key question has remained 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; continuous learning and improving care

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 17.

• Since the last inspection, a further manager had been appointed and left the service. There was an acting manager in charge of the day to day running of the home. However, they had insufficient knowledge and understanding of the risks in the service and of individual people's care.
• There was a newly promoted deputy manager who was experienced in working within the home and who knew people well. They were beginning to work as part of the management team, but it remained unclear who was responsible for which aspects of managing the service across the senior management team and there was a lack of accountability, understanding of risks and oversight.
• The regional manager attended the home twice a week, but they had insufficient oversight of the quality of the service and the governance systems were not robust. They told us they had trusted the previous manager to complete quality checks, without any oversight from themselves.
• None of the management team were able to identify a service improvement plan or action plan from the previous inspections, and confirmed there was no such plan in use for the breaches identified by CQC. This was later provided, with many actions showing as addressed. However, we found they had not been effective in addressing the existing breaches of regulations, or preventing further breaches.
• Clear and robust systems of audit were not evident. Some quality checks had been made, such as twice daily walkarounds, but these did not identify the most basic concerns found during this and previous inspections. For example, people were without call bells, drinks and oral care. There was no analysis of weight loss, accidents and incidents in the home, or evidence of learning and driving improvement from previous concerns. Recording of people's care was of extremely poor quality.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• At all previous inspections of this home we found the culture of the service meant people had to fit in around the running of the home.

• People continued to have insufficient control over their day-to-day routine. People were not always in control of where they spent the day or when they were able to have their meals. The management team were aware of these concerns since the first inspection of this service, but action had not been taken.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to assess, monitor and improve the safety of the service were not in place.

• Following the inspection feedback, the provider advised us of improvements in progress and their intentions to develop and embed a more robust system of auditing and governance. Whilst some action had been taken, this was reactive to this inspection, even though the same concerns had been raised repeatedly during previous inspections, with assurances given from the provider each time.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There was mixed feedback in how people and relatives were involved and engaged with the service. Staff told us they felt informed and involved in how the home was run.
• Not all people and relatives knew who was in charge of running the home. Some people felt the home ran well, although one person said, "Sometimes they are not organised, they are all over the place and they don't seem to click. I don't know who the manager is, they keep changing." One relative said, "I would say it is well run. The managers come and go, they want to get it right."
• Relatives told us they were kept informed if there were any concerns involving their family members. and said there were meetings they could attend to discuss general issues. One relative said, "I asked for the minutes from the meetings to check if they have done things they said they would do. Some [things] are done and some are not."
• People's equality characteristics were not always considered, but care plans were still in the process of being improved and we were told by the provider this information was expected to be included.

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; Working in partnership with others
• The provider was aware of their responsibilities under the duty of candour.
• Health professionals were referred to where necessary in support of people's care. Local authority partners told us the service engaged in feedback given, although actions had not always been sufficiently addressed.
• The provider told us they were responsive to feedback and keen to introduce ways of working which would drive improvement. However, they were unclear about the reasons for reoccurring breaches in regulations. They told us about possible ways to move forward using feedback received from all stakeholders.