Mrs Susan Mary Robinson

Robleaze House

Inspection report

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Date of inspection visit:
22 April 2021
27 April 2021

Date of publication:
14 June 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Robleaze House provides accommodation with personal care for up to 10 people with a learning disability. At the time of our inspection 10 people were living in the home. Four people had lived there since the home opened 26 years ago.

The service was operating before the principles and values that underpin Right support, right care, right culture had been developed. However, the service would be expected to develop in line with these principles and other best practice guidance. Right support, right care, right culture ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

People using the service should receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. However, the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home.

People's experience of using this service and what we found
There were areas found at the last inspection that meant the provider was in continued breach of requirements such as the failure to report incidents they have a legal responsibility to report to the Care Quality Commission.

Some of areas of the home still needed ongoing maintenance to ensure they were in a good state of repair. This was impacting on the cleaning of the home, which was vital in the management of infection control especially during a pandemic.

Not all areas of the home were clean and free from odour, however, this was addressed by day two of the visit. Cleaning schedules had not been signed as being completed.

As seen at the last inspection, the provider did not have effective systems in place to consistently assess, monitor and improve the quality and safety of the service and ensure regulatory requirements were met.

There had been some improvements noted since the last inspection, in areas such as records relating to people who lacked capacity and how decisions had been on their behalf. Where people lacked capacity, appropriate applications for a deprivation of liberty safeguard had been submitted.

Improvements had been made to ensure systems were in place to ensure people received their medication safely. There had also been improvements to the reporting of allegations of abuse, staff training, appraisals, supervisions and staff meetings.

People and their relatives spoke positively about the care and support provided by the staff and the registered manager. Some people had lived at the home for many years. This was a family run business. Staff knew people well.

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. The provider said that it had been difficult during the pandemic with the restrictions in place and keeping people safe. However, people had been involved in decisions about activities, menu planning and COVID-19 testing and vaccinations.

Some improvements were needed in respect of meeting some of the underpinning principles of Right support, right care, right culture. Care plans focused on what the person could and could not do with little focus on people's hopes and aspirations.

Care plans were in the process of being reviewed. Triggered in part by this inspection, with information being put in one central file for each person. New assessments were being completed which would inform the new care plan for each person.

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 October 2019). There were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been sustained and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective, responsive and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to the home environment, which was not properly

maintained, and the lack of effective systems were not in place to continually monitor and improve the service. The provider had continued to fail to notify us of incidents which they legally need to report

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.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

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Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Robleaze House

Detailed findings

Background to this inspection

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

Service and service type
Robleaze House 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.

The provider is legally responsible for how the service is run and for the quality and safety of the care provided because they are a sole trader, they do not need a registered manager.

Notice of inspection
The first day of the inspection was unannounced and the second day was announced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with three members of staff including the provider, the deputy manager and a member of staff.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance audits completed by an external assessor. We sought further feedback from a visiting professional who regularly visited the service, spoke with one member of staff on the telephone and three relatives.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We noted on our first day some of the areas in the home were unclean such as skirting boards, there were dark marks on the walls in the small lounge from drink spillage and a leather sofa in the main lounge was pealing making it difficult to clean. Improvements had been made by day two and all areas had been deep cleaned. There were significant recording gaps in the daily, weekly and monthly cleaning schedules. Some areas of the home were in a poor state of repair which meant areas could not be effectively cleaned.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure appropriate safeguarding systems and processes were in place to protect people from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

- Systems and processes were in place to ensure people were protected from the risk of harm or abuse. The provider was able to demonstrate that they had liaised with the local safeguarding team and commissioners in respect of one person's behaviour where it had escalated due to the pandemic.

● Safeguards had been put in place to protect the person and others. This included the person having additional staffing hours to support them with their anxieties from the pandemic and the restrictions this had imposed on them in relation to their usual routine.
● Staff had completed training in safeguarding and knew what to do to keep people safe. A member of staff said they would have no hesitation in reporting any concerns to the provider or the deputy and they were aware of the external agencies they could contact.
● Relatives were confident their loved ones were safe, and they would let them know if there were any concerns.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Risks to people were assessed and monitored. People now had a risk assessment in place for emergency situations such as fire, previously only two people had these in place. An external contractor had completed checks on the fire equipment.
● An external auditor had completed a fire risk assessment. Areas for improvement had been actioned including the replacement of a fire door leading to the laundry and other remedial works.
● In response to our last inspection, a missing stair rail had been replaced enabling people to use the stairs safely.
● There were risk assessments in place to keep people safe when doing activities, for example, household chores, eating and drinking and moving and handling. These had been kept under review.

Staffing and recruitment
● People were protected by safe recruitment practices. A thorough recruitment process had been followed with staff who had been newly employed, which included seeking two references and a Disclosure and Barring Service (DBS) check. These had been carried out to check whether staff were suitable to work with people in care homes. The records included confirmation that gaps in employment history had been checked.
● The provider said two staff had recently left, but the vacant posts had been filled. They also used regular and familiar agency staff to support with one to one hours.
● A member of staff told us there was enough staff and the provider, or the deputy manager would always help when needed. The provider said they often supported the people in the home especially since the pandemic due to people being home instead of going to their community-based activities.
● There was one member of staff providing support at night. There was an on-call member of staff who could assist at night or in the event of an emergency. The provider said they could also respond as they only lived five minutes away from Robleaze House.

Using medicines safely

At our last inspection the provider had failed to ensure medicine management was safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● People's medicines were managed safely. Temperature checks were now being completed to ensure medication was stored at the correct temperature, with records maintained. A member of staff confirmed advice from the pharmacist had been sought and formed part of a risk assessment with guidance to staff if the temperature went above the ideal range.
● Some people took homely remedies (over the counter medicines) such as paracetamol or cold relief remedies. Advice had been sought from the GP on whether these were safe to use alongside their prescribed medications.
● Medication stock checks were completed on medication entering the home including a running stock check which helped with ensuring medicines were being given in line with the prescriber's instructions. A member of staff had now taken on this responsibility and checked regularly that medication was being given correctly and staff competence was regularly checked on the giving of medicines.
● Staff administering medicines had received training as part of their induction.

Learning lessons when things go wrong
● Accidents and incidents were recorded. These had been reviewed by the provider and actions were put in place to prevent recurrence where possible. For example, the television in the lounge was protected by perspex to prevent a person removing this from the wall.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

At our last inspection the provider failed to ensure the premises were properly maintained ensuring the needs of the people were being met. This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Whilst some improvement had been made since the last inspection, the provider was still in breach of regulation 15.

- The home was in need of maintenance and repair. At our last inspection we found similar issues that repairs were not always completed in a timely way.
- The flooring in the lounge and office had holes in them which were a potential trip hazard for people and looked unsightly. The provider informed us this had been due to be replaced but was delayed due to the pandemic. An email was seen confirming an external contractor was involved in the replacement. The sofas in the main lounge were in a poor state due to one person picking at the material.
- The roof had leaked causing a damp patch in one person's bedroom and the office. The provider said they were in the process of getting quotes for this to be repaired. We saw this recorded on a maintenance report. The external kitchen window frame was rotten and required some attention.
- Three bedrooms were in a poor state of decoration. One of the bedroom's walls had been re-plastered but was yet to be decorated. This had been noted at the last inspection. The sink in this room had been removed and needed replacing. In another bedroom a person had removed the skirting boards.
- There was a broken chest of drawers in two of the bedrooms and in another there was a sink unit with a missing door.
- Sealant round baths in both communal bathrooms was black and in one bathroom there was no grout between the tiles. The soap dispenser in the ground floor toilet had not been secured to the wall after a person had pulled it off
- A relative told us, "The home is clean and homely but tatty, and looking very tired".

The premises were still not properly maintained ensuring the needs of the people were being met. This was a continued breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Since the last inspection the provider had completed the refurbishment of the laundry area and put in a wet room on the ground floor and the kitchen had been replaced. Some new furniture had been purchased for the dining room as this had been destroyed due to the behaviours of a person. Two people were very proud to show us their bedrooms which were comfortably furnished and decorated.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Not everyone had a health action plan. A Health Action Plan is something the Government said that people with a learning disability should have. This is an accessible plan that belongs to the person that describes what things they are doing to keep fit and well. The provider said this was work in progress and would be contacting the local community disability team for their support in this area to ensure this was in place for everyone living in the home.
● Assessments were carried out prior to people moving into the home to ensure their needs could be met.
● Staff were in the process of completing new assessments for each person which would then inform people's plans of care.
● People now had a hospital passport which included important information in the event of an admission to hospital. This was in part driven by the pandemic and our findings at the last inspection.

Staff support: induction, training, skills and experience
At our last inspection the provider failed to ensure there were systems in place to monitor, support and train staff. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Systems were in place to ensure staff were supported and trained. Two staff had recently started working in the home and were in the process of completing their care certificate and in-house induction. The provider said allocated time needed to be given to one part time member of staff, to enable them to complete this in a timely manner.
● Since the last inspection the provider had changed to a new external training provider. Staff were in the process of completing the training available to them. Much of this was done electronically. Fire training was now being provided annually.
● The provider said during the pandemic it had been difficult to organise regular supervisions. There was a plan in place to ensure this was addressed. All staff had received an annual appraisal in either February or March 2021.
● In the absence of regular meetings, newsletters and handovers had ensured staff were up to date with information relating to COVID 19 and government guidelines.
● A member of staff told us they felt supported and the training was good. They were in the process of completing a qualification in care with an independent assessor.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they had enough to eat, drink and liked the food. One person said, "I don't like tomatoes or cucumber, but I like cheese". It was evident an alternative would be found if a person did not like what was on offer.
● People were seen helping in the kitchen with food preparation and making drinks, either with staff support or independently.
● There was a four weekly menu available to people. The provider said at the beginning of the pandemic some food items were difficult to get such as pasta, but they organised online deliveries and they had

managed.
● We observed the mealtime experience and saw people were supported with their meals where required. Staff were patient and kind when supporting people. The meal was relaxed and unrushed.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support
● The provider confirmed they had been supported by health professionals during the pandemic either in person or virtually. There was weekly contact from the GP surgery and people had been supported with their annual health checks and support to attend optician and dental appointments.
● People had been supported to have an annual health check with the GP practice. Everyone had also received both COVID-19 vaccinations.
● A health professional told us following an annual review, a person required further investigations which required support to an outpatient appointment. The staff made the necessary arrangements and supported the person to attend. The health professional reported that staff knew people well and they looked well cared for when they visited the home.

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.

At our last inspection the provider had failed to ensure people were fully involved or protected when decisions were being made. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● Systems were in place to protect and involve people when making decisions. Applications had been made for six of the ten people living in the home. Five had been authorised and one person was being assessed. Initially this information was difficult to navigate as not all documentation was in the home's file relating to these applications, but on the computer. By day two of the inspection all information was logically stored in the file with an index and an overview when applications were authorised and required renewing. This enabled the provider and staff to monitor at glance what was needed.
● Since the last inspection action had been taken to assess people's mental capacity to determine if an application to deprive a person of their liberty was required and what support each person needed when

making decisions about their care and support. Previously this had been because health and social care professionals had recommended this be completed.

● People's consent had been sought and recorded prior to administration of the COVID-19 vaccinations. Accessible information had been sought to enable people to make an informed decision and where people needed more support health and social care professionals and family had been involved to ensure it was in the best interest of the individual.

● People's care plans gave guidance on where they required support and the prompts needed to help them make decisions and choices.

● A relative said they were always involved and consulted about the care and support and recently this had included whether their loved one should have a COVID vaccination.

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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Some improvements were still needed to ensure people' care was personalised. As seen at the last inspection, there was still no goal planning or evidence that people were fully involved in their care, which would be in line with the principles of the Right Support, right care, right culture. Care plans focused on what the person could or could not do and were about daily tasks rather than people's aspirations. The provider said this had been difficult due to the pandemic but would reintroduce this with keyworker time being allocated.

● We found at the last inspection and on our first day of this inspection people had care plans that detailed some areas of the support they needed and what they could do for themselves. However, there was no link in people's care plans to risks assessments, mental capacity and deprivations of liberty, which were stored in a separate generic file. This meant the information staff needed to know was not joined up with clear links on how to support people safely and consistently. Some information was stored in a drawer and not within the person's care files such as consent to have the vaccination.

● After the first day of the inspection action had been taken to ensure all information about a person was in one central file. They had completed this for six of the ten people. The care files now included a pen picture of the person, their likes and dislikes, plans of care, medical information and other correspondence relating to the person. The provider provided us with assurances that this will be completed for everyone living at Robleaze House.

● Staff were in the process of re-assessing each person which would then be used to inform the individual's new care plan moving forward.

● It was evident that some improvements had been made in respect of our findings from the last inspection, but this needed to be embedded into practice and the culture of the home.

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 individual communication needs were identified. Support plans included a section, 'Communication' which guided staff on how to communicate with people.

● Some information was provided to people in accessible formats, this included easy read and pictorial formats. This included information about the pandemic, the vaccination and, raising a complaint.

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

● People were supported to maintain relationships with family and friends. People and relatives confirmed they had been able to keep in contact during the pandemic with regular phone calls and visits in line with government guidance. A gazebo in the garden had been decorated at Christmas to enable people to spend time safely with family. Patio heaters had been purchased to make the area more comfortable.

● People were supported to take part in activities both in the home and the community. People told us they had completed a variety of activities including baking, gardening, gentle exercise and arts and crafts and going for local walks taking into consideration government guidance. At Christmas they had joined a virtual concert with the Old Vic. A member of staff said, "We aim to do activities daily except Sundays when people can have free time and relax in their own home."

● People were slowly returning to various activities in the local community including a trampolining group and community-based activities. Three people had found not attending their centres difficult as they had attended them for many years. These were gradually opening, which had improved their individual wellbeing with a reduction in some behaviours that had challenged the service and the environment.

● Additional hours had been given to one person and a dedicated member of staff had supported them during this period. Records of these hours and the support given had been recorded up and until the point they had returned to the day centre.

Improving care quality in response to complaints or concerns

● The provider said they had not received any complaints since the last inspection.

● Relatives said they were happy with the care and support given to their loved ones especially during the pandemic with regular contact taken place.

End of life care and support

● The provider told us at the last inspection they would work closely with other health and social care professionals and specialists in supporting people with end of life. This would include seeking the views of the person and their relatives. At the time of our inspection no one was receiving end of life care.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now deteriorated to Inadequate. We found that improvements had not been made and identified three continued breaches of the regulations and consistency of good practice was not demonstrated.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection, the provider failed to notify the CQC of incidents they were required by law to tell us about. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

- We found at the last inspection; the provider had not ensured they had notified the CQC of incidents they were required by law to tell us about. This is so we can check appropriate action has been taken.
- After the last inspection, the provider had informed us about the authorisations of the deprivation of liberty safeguards (DoLS) in response to our findings. However, these had since expired, and new authorisations had been put in place for five people. The provider had failed to notify us of this.
- In addition, we found we had not been notified about two incidents in October 2020 where the police were called to Robleaze House. The provider had informed the local authority safeguarding team; however, they had failed to notify the Care Quality Commission.

This was a continued breach of regulation 18 (Notifications of other incidents) of the Registration Regulations 2009.

- The provider understood their responsibility to contact relatives after incidents. Relatives told us the provider was approachable and open with them.

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

At our last inspection the provider failed to ensure there were robust systems in place to monitor and improve the quality of care. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated

Activities) Regulations 2014.

● Systems were not in place to maintain and drive improvement. As noted at the last inspection quality audits were not robust to demonstrate what areas had been checked for compliance. Whilst the provider completed monthly checks on the environment, medication, care plans, training, supervision and other areas relating to running a care home. There was no break down on what was checked, what the expectations were or a robust action plan where things were not working well. This meant we could not be fully assured all checks had been completed and the necessary action taken.
● There were significant failings in the cleanliness and upkeep of the environment. There had been a slow response to repairs and maintenance as found at the last inspection. There were no action plans in place to drive improvement in these areas.
● At the last inspection we found that not all care documentation was stored in a central place. Information was stored in various generic files, on the computer and in the office drawer. This made it very difficult to navigate and find the information that was current for each person. We found the same during this inspection.
● This is the second consecutive inspection where the home has failed to achieve an overall rating of good, and the fifth consecutive time the home has failed to achieve good in the Safe domain. This demonstrates the provider has failed to implement systems and processes which will robustly assess, monitor and improve the quality and safety of care provided.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate enough good governance. This was a continued beach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the second day, the provider showed us some quality checks that they were planning to put in place. These needed to be embedded into the culture and practice of the home.
● The provider after the last inspection had commissioned an external auditor to complete checks on the health and safety and fire systems within the home. Where shortfalls had been found, remedial action had been taken to address these.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Improvements were needed to ensure people's long-term goals and aspirations were being met. The provider said this had been difficult due to the restrictions imposed by the pandemic because everyone had remained at home rather than attending community-based activities or spending time with family at weekends. Moving forward and as restrictions were being lifted people were returning to their day placements and slowly doing more in the community.
● People were involved in day to day decisions about menu planning and the daily activities that they wanted to participate in. They were aware of the pandemic with one person telling us the importance of social distancing and washing hands.
● The provider talked about their values, which were known and understood by the staff we spoke with. It was evident that Robleaze was people's home first and foremost where they felt included. A member of staff said there is always a lovely atmosphere in the home with people enjoying banter between themselves and the staff. They said, "I really enjoy working at Robleaze".
● Relatives spoke positively about the care and support. A relative said, "It felt homely from the first day we visited. All the staff are caring and enthusiastic cannot fault them, it is excellent". Relatives told us the staff knew their loved ones really well. Two relatives told us how their loved ones had thrived since living in the home and were learning new skills and doing things they had never done at home.

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

● People, staff and relatives were engaged and consulted about the care provided. Relatives we spoke with commended the level of contact they had with the staff and their family member prior to and during the pandemic. Regular phone calls and garden visits had been organised in line with government guidance. People confirmed they had been supported to maintain contact with family.

● A recent survey had been completed by family. All feedback was positive including how the service had managed the pandemic and maintained contact with them. A relative had written, 'I agree with all that you have done to keep people safe, including closing the home to visitors.'

● A member of staff said they had been supported in their role. Although team meetings had not happened due to the pandemic, these were being reintroduced. They said there had been regular newsletters and written communication about the pandemic and life at Robleaze to ensure they kept up to date with changing guidance.

● Two people were very keen to show us their new electronic devices, which enabled them to keep in contact with family and were used for various other functions including watching films.

Working in partnership with others and continuous learning and improving care

● The provider said the pandemic had been a difficult time, but they had maintained regular contact with health and social care professionals. Good communication had been developed between the GP practice and the service with weekly calls of support.

● Some frustrations had been experienced, when a person's behaviour had escalated and the lack of response and support at the actual time of the incident from an out of hours service. However, plans had been developed with other professionals to reduce the person's anxiety around the pandemic and the changes of routine that had been imposed on them. The provider said people were more settled now as restrictions were being lifted.

● People and staff had remained COVID free since the start of the pandemic. Links had been built with the local authority and Public Health England. The deputy told us they had attended weekly meetings to ensure government guidance was followed.

● The provider told us they had changed their inhouse training provider. Staff were in the process of completing the training. The system provided alerts to staff and the provider when training was due which enabled them to monitor progress.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises used by the provider was not properly maintained. Regulation 15(1)(c)(e)

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 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were not sufficiently effective to monitor and improve the quality and safety of the service. Regulation17(1)(2)(a)(b)(c)(f).

The enforcement action we took:

We have issued a warning notice telling the registered person they must make the required improvements by the 30 September 2021.