The Christian Care Trust

Grace House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 18 and 22 March 2016. Our previous inspection of September 2013 found that the service had addressed concerns with staff supervision and training, and effective governance, which we had previously identified.

Grace House is a care home for up to ten people that specialises in the care and support of older people and people living with dementia. There were two vacancies when we inspected.

The service had a registered manager. 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 and associated Regulations about how the service is run.

People using the service and visitors provided good feedback about the service. They were satisfied with the staffing levels and said the staff team were caring, attentive and provided the support they needed in a friendly and kind way. They were also happy with how the service was managed.

We found that the service was caring. Staff provided professional and attentive support to people in a caring manner. The care was centred on people's individual needs and preferences. The service supported people to eat nutritious diets and drink enough. People's health needs were addressed, including through the support of community healthcare professionals.

The service provided sufficient numbers of staff, and standards of cleanliness were maintained. Staff benefitted from regular training, particularly the new National Care Certificate which is a set of minimum standards that staff should uphold in their daily working life and which new staff must be trained on.

However, we found some significant concerns about how the service was operated that particularly undermined people's ongoing safety. Criminal record checks and appropriate references were not in place for a number of newer staff, meaning the provider had not taken necessary steps to ensure that these staff were safe to work with people.

Records could not demonstrate that people were consistently offered their medicines as prescribed. There were also shortfalls with the security of medicines and with ensuring emergency first-aid kits had equipment that was not out-of-date.

Risk management processes were not comprehensive. They did not ensure that all reasonable actions were taken to minimise risks to people using the service. Parts of the premises were avoidably cold during one of our visits. Following an accident to one person, we could not be assured that sufficient action had been taken to minimise the risk of reoccurrence.

Whilst efforts were made to address people's needs in practice, people's care plans did not consistently address all their support needs and sometimes contained contradictory information. This had potential to undermine appropriate care practices.

Records of the care provided to people, and of the management of the service, were not consistently up-to-date and complete. This undermined appropriate care practices and meant information could not always be easily accessed.

The service had not embedded the principles of the Mental Capacity Act 2005 into its practice. Whilst some people were being deprived of their liberty for their protection, applications to undertake this lawfully had not been made.

We also found concerns with how well-led the service was. There were few recorded governance systems in place, and so we identified shortfalls that the management team and the provider had not recognised or addressed.

The provider had not kept us notified when significant events occurred at the service, contrary to legislation. This prevented us from monitoring the service effectively.

There were overall eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulations 2009. We are taking enforcement action against the registered provider. We will report further on this when it is completed.

The overall rating for this service is 'Inadequate' and the service is therefore 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 and 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, and if there is not enough improvement so there is still a rating of inadequate for any key question 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. Recruitment practices did not establish whether staff were of good character. Criminal record checks and appropriate references were not in place for some staff providing care and support to people.

People's medicines were not robustly managed so as to maintain an audit trail that demonstrated that people were consistently offered their medicines as prescribed.

Risk management processes were not comprehensive at ensuring that all reasonable actions were taken to minimise risks to people using the service.

People were protected from abuse by effective safeguarding procedures. The service provided sufficient numbers of staff, and standards of cleanliness were maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective. The service had not embedded the principles of the Mental Capacity Act 2005 into its practice. Whilst some people were being deprived of their liberty for their protection, applications to undertake this lawfully had not been made.

People received care and support from trained staff who received adequate supervision. The service supported people to eat nutritious diets and drink enough. People's health needs were addressed, including through the support of community healthcare professionals.

Is the service caring?

Good

The service was caring. People felt respected and were involved in decision-making about their care.

Staff provided support in a kind, professional and attentive way. The care was centred on people's individual needs and preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Whilst efforts were made to address people's needs in practice, people's care plans did not consistently address all their support needs and sometimes contained contradictory information.

People were encouraged to raise concerns informally. The service responded to this.

Is the service well-led?

Inadequate

The service was not well-led. There were few governance systems in place, and so we identified shortfalls that the management team and the provider had not recognised or addressed.

The provider had not kept us notified when significant events occurred at the service, contrary to legislation. This prevented us from monitoring the service effectively.

Records of decisions about care, the care provided to people, and the management of the service were not consistently up-to-date and complete. This undermined appropriate care practices and meant information could not always be easily accessed.

Grace House

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.

This was an unannounced inspection which took place on 18 and 22 March 2016. The inspection team comprised of two inspectors and an expert by experience which is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service including any notifications they had sent us and information from the local authority.

There were eight people living at the service at the time of our visit. We spoke with three people using the service, three visitors, six staff, the registered manager and the office manager. We observed care delivery in communal areas, and we looked at selected areas of the premises.

We looked at care records of three people using the service, personnel files of six staff, along with various management records such as quality auditing records and staff rosters. The office manager sent us some further documents on request after the inspection visit.

Inadequate

Is the service safe?

Our findings

People and their relatives said they thought the service was safe. We saw staff pay attention to people's safety during the visit, for example, in supporting people to move around the service where needed.

One person, however, told us they felt cold in their room by the front door. We found that both downstairs rooms by the front of the house were cool, and we noted that the front door had a small gap underneath by which a draft could come through. The registered manager told us the front door had been recently replaced, and that remedial work was needed to address the gap. We also noted that the heating went off during the day for a while, rendering some communal areas cooler. When it came back on, we found that the safety-covered radiator in the room of the person in question did not produce a lot of heat. The management team told us the heating went off in error, and that there was no recent professional check of radiators to ensure they were working well. This did not demonstrate proper maintenance of the premises.

When we checked the service's first aid kit, we found a number of items within it were out of date. This included three sterile dressings that expired in 2012, one that expired in 2011, and a sterile eye pad that expired in 2013. This did not demonstrate proper maintenance of emergency first aid equipment.

The evidence above demonstrates a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

When we checked the service's accident book, we found that one person had been taken to hospital in the autumn of 2015 following a fall at the service. They had sustained a fractured wrist. The office manager told us that they had established that all staff present in the service at the time had been busy attending to other people, and so the accident was not avoidable. However, they confirmed that there was no documented plan to minimise the risk of reoccurrence. In terms of minimising risk, we noted that there was no visual highlighting of the step involved in the accident, which could highlight to some people of the change in level. We were, however, informed to be careful of the step. Risk assessments for the person involved in the accident were contradictory. Their falls risk assessment recorded them as "unsteady" and so staff were to accompany them "at all times." However, the section of their care plan titled "walking round the home" stated that they did this independently. The office manager told us that staff could not always accompany this person. We also noted that the person had not been supported to have an optician's assessment despite using the service for over six months. This failed to demonstrate that all reasonably practicable actions were being taken to mitigate risks to this person and other people using the service in support of providing them with safe care.

There were individual risk assessments for people in respect of matters such as their health and aspects of daily living. The risks were kept under review and updated when people's needs changed. However, the assessments did not clearly indicate what action was being taken to reduce identified risks. We also noted that where assessments used a scoring system such as for dependency and pressure ulcer prevention, the scores for individual people frequently varied over time, which may have compromised the accuracy of the assessments. For example, recent consecutive pressure care risk assessments reduced the risk for one

person from high to none, despite there being no documented record of actions taken to reduce the risks.

The service had systems for supporting people with medicines management. We noted that records showed that someone receiving an antibiotic was correctly administered the course promptly and consistently. Two people were prescribed a variable dose medicine that required regular blood tests. We saw that results of the blood test caused revised prescriptions of the medicines, which the service subsequently set up correctly so that these people received the medicines as prescribed.

However, the medicine records for people using the service were not consistently completed and up to date. For example, the records of administering one person's two eye drops across the previous two weeks had three signature gaps. The medicine for one person at 1500 hours on the day of our first visit had not been signed at 1630 hours, although we were told that it had been given. There were no records of the quantities of people's medicines being received by the service, which meant that it was not possible to audit so as to check that remaining stock matched records of administration.

There was a controlled drugs register that had each entry countersigned by two staff members. This helped to ensure an audit trail of the controlled drug kept for one person. However, we noted that the controlled drug was not securely stored as it was in a money box within the medicines cupboard rather than a wall-mounted and locked section of that cupboard. The controlled drug could therefore be removed if access was gained to the medicines cabinet. We noted that medicines such as eye drops stored in a designated fridge could be removed as the fridge had no lock. The office manager told us that a visiting pharmacist had previously stated that a lock for the fridge was required. When we returned to the service a few days later, we saw the fridge remained without a lock, and found the door to be ajar by few centimetres which compromised the temperature control. This did not represent safe management of these medicines.

One person was recorded as not receiving a once-weekly prescribed medicine for osteoporosis, nine days before our first visit. The office manager told us they were not aware that this occurred and did not know what the medicine was for. Another person was recently recorded as not receiving a medicine at the prescribed time albeit they had them somewhat later. In both cases, there was no recorded reason on the medicines records about why these medicines had not been given as prescribed. The office manager was unable to show us a sheet of staff signatures, by which to identify which staff had signed for which medicines. One person's as-required medicines did not explain what it was for and limitations on use, albeit the member of the management team could tell us. This did not represent safe and proper management of people's medicines.

The management team told us that two staff worked together to administer medicines. However, records of administration were not consistently made despite this precaution. The management team could provide us with no medicines audit records, either from a pharmacist or senior staff. They could not provide records of assessment of staff capability for medicines management on request, just confirmation that staff had received training. This did not represent safe and proper management of medicines.

The evidence above demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider's recruitment processes did not ensure that the good character of new staff was established. We checked the recruitment documents for six staff employed in the last four years. There was no criminal records (DBS) disclosure or application for three of these staff members. The criminal record disclosure for a fourth staff member pre-dated their employment by over a year, when the DBS guidance states a three-month maximum length of portability. The date on a fifth disclosure was not clear, so we

could not establish if the provider acquired it in good time. Reasonable precautions had not been taken to ensure these staff were safe to work with people using the service.

We found that two current staff members had information of concern on their criminal record disclosures. There are circumstances where the provider may consider that the disclosure provides minimal risk to people using services if certain precautions are followed. However, there were no records of the provider's assessments and precautions in respect of these risks. In one case, the management team told us the staff member declared the information of concern at interview. However, none of the staff files we saw had any record of what occurred at interview. These omissions did not demonstrate that reasonable precautions had been taken to ensure these two staff were safe to work with people using the service.

Of the six files we checked for staff who started work in the last four years, five did not have appropriate written references in place. Two did not have any written references and two others had only one written reference. One of these was from a colleague employed at an overseas care service that was dated over seven months after the start date on their employment contract. There was nothing on file or made available to us to show that attempts had been made to contact the employer for a reference. This staff member had gaps in their employment history, but there was no record of exploring reasons for that. There was usually no record of why candidates had left previous employment, and in two cases, there was no application form. None of the files had records of considering the candidates' physical or mental health conditions relevant to their capability for the work they would be undertaking with people using the service. These omissions did not demonstrate that reasonable precautions had been taken to ensure these staff were of good character and safe to work with people using the service.

The evidence above demonstrates a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of visiting, we asked what action was being taken in respect of our concerns about safe recruitment on the first day. The management team told us they had registered with an organisation that could provide criminal records disclosures within 10 days. We saw emails confirming correspondence about this.

The service had policies and procedures for protecting people from abuse and harm which staff had signed as read. Staff had received safeguarding training and were aware of how to raise a safeguarding alert and the circumstances under which this should happen. They all reported that they would inform the registered manager primarily. Comments included, "We have been told about whistleblowing." Staff also confirmed that they were required not to accept gifts.

The fire authority had recently checked the service and required improvements, which they subsequently found to have been undertaken. One person we spoke with told us they did not like their bedroom door closed now due to the fire authority advice. The registered manager told us that further changes were planned including installing equipment to close fire doors on the activation of the fire alarm.

There was equipment and fittings around the service to help maintain safety. This included handrails for the stairs, a passenger lift, restrictors to prevent windows opening too far, and covers for radiators so that people would not get scalded against them. There were locks to the inside of people's doors for privacy, but which could be overridden in case of emergency. People assessed as needing pressure care equipment had equipment in use.

People and their relatives told us they thought there were enough staff to meet their needs. We found this to

be the case. The numbers of staff on shift during the inspection matched those on the staff rota. This supported staff to meet people's needs in a safe and unhurried way.

We saw that the premises were clean throughout our visit. Care staff had some responsibilities for maintaining standards, but there was also a cleaner present from the start of our visit. The management team told us they were employed three days a week. We saw that staff had easy access to personal protective equipment, by which to help control infection risk when supporting people with personal care. We noted that the kitchen and food hygiene systems received a five-star rating from the Food Standards authority in the autumn of 2015.

Requires Improvement

Is the service effective?

Our findings

People and their relatives gave positive feedback about the effectiveness of the service. They told us their needs were met by staff who knew what they were doing. One person said, "I can't say anything bad about the staff because am happy coming here."

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. The application procedures for this in care homes and hospitals are 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 were being met. We found that there had been no applications made to the relevant 'Supervisory Body' to lawfully deprive people of their liberty. Whilst it was clear that some people were free to leave the premises without continuous staff supervision, the management team rightly considered other people to be at risk if that was to occur. For example, they told us that one person sometimes wandered, but was prevented from going out due to a key-code system at the front door.

The management team told us they had been trying to liaise with the local authority in respect of decisions about one person who they had supported to move into the service. They told us of another person who had recently been stating that they wanted to go home. However, they confirmed that no DoLS application had been made for these people. Whilst the service may be acting in these people's best interests, the lack of DoLS applications meant any deprivations of liberty were not being undertaken lawfully.

When we checked people's files, we did not find evidence of capacity assessments, best interest decisions, or clarifications on lasting power of attorney statuses and how that may impact on the care being provided. This was despite the management team telling us that most people using the service lacked capacity to consent to their care.

Staff we spoke with had a rudimentary understanding of working in line with the principles of the MCA. They all confirmed that the registered manager had provided recent training on the MCA, but one staff member could not explain what they had learnt as a result of this and how they applied the MCA in their care and support of people.

The registered manager told us their last training on the MCA was a number of years ago. The management team could not demonstrate a proper understanding of the principles of the MCA, the specific expectation

to apply for DoLS on behalf of relevant people they continuously looked after, or how recent changes to how MCA principles were being updated in line with supreme court judgements. The provider was not yet ready to follow the principles of the MCA.

The evidence above demonstrates a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt the service supported them with their specific health needs. For example, one person told us they received regular visits from a chiropodist. Staff said they followed people's care plans in terms of meeting specific health needs. We saw the office manager liaising with one person's GP in respect of new health concerns and associated risks relating to medicines the person was taking. This resulted in the GP visiting the person a few hours later. The office manager told us of a concern for the health of another person and how they were continuing to liaise with a GP about this. We saw records of antibiotics being prescribed and administered to one person as a result of liaison with a GP due to the person having symptoms of poor health. Records also demonstrated the involvement of healthcare professionals such as district nurses where needed, and that people were supported to attend blood tests.

People told us they enjoyed the meals provided. A relative said, "The food is really good. [Their relative] really enjoys it; there is a choice and they get enough." People told us that a variety of meals were provided. The lunch we saw was well presented, nutritious and hot. Desert was also routinely provided. Meals were monitored to ensure they were provided at the correct temperature. Home-cooked snacks such as biscuits and cakes were provided, along with a pre-prepared home-cooked pizza as part of the evening meal. The cook told us of home-made soups also being routinely provided. We saw a good supply of raw foods available for this. The cook also said that when anyone did not like a meal, which was rare, an alternative was provided.

We saw that people were supported to eat their meals where needed. One person was provided with a straw, for example, to enable them to drink independently. We saw records of a recent meeting to discuss how to better support one person to eat well, based on providing choices and understanding the person's specific needs. We also noted that people's specific preferences and needs around diet were recorded.

Staff reported that they were supported and trained to carry out their roles and responsibilities. Their comments included, "I get the help I need." The registered manager told us she had been holding monthly training sessions with staff on the principles of the new national Care Certificate which is a set of minimum standards that staff should uphold in their daily working life and which new staff must be trained on. We saw individual staff files full of resources and answered questions in respect of this. Records also showed that half the staff had certificates of completing national training courses in care such as NVQs, including some at advanced levels, which staff confirmed to us. Staff were therefore able to demonstrate care knowledge, for example, on dementia.

Most staff reported receiving supervision sessions and team meetings every couple of months. However, the office manager told us that annual supervision and appraisal meetings took place for each staff member, which matched records we saw across the last year. Team meeting records showed only one such meeting for all staff in the last year. The registered manager confirmed that team meetings were infrequent as staff did not engage in that process so well, however, issues were dealt with immediately instead, for which we did see occasional records of group supervisions.

Good

Is the service caring?

Our findings

People and their relatives told us that they were treated with dignity and respect. A relative said, "The best thing about the service is that it's like a family home. It feels like you live there rather than a clinic. It has a family inclusiveness to it."

We overheard staff interacting with people in a caring manner. We heard staff say such things as "You look lovely" and "We'll make you comfy." We heard staff notice if people needed attention, such as when someone had a nose-bleed. We also heard staff engaging well with people to help them to move, for example, "You can hold on there and stand up." Attention was paid to supporting people with their appearance. We saw staff provided extra cushions to someone who was leaning over in their chair, to support them and provide better comfort. However, one person was also bent over in their chair for a long period across lunch without staff offering them additional support. The registered manager told us the person often refused support, however, staff were not checking if that remained the case.

We saw staff treat people in a respectful, interactive and caring way. New staff coming on shift took the time to greet people. A staff member sat and interacted with people when eating their meal after people had had their lunch. People's doors were generally knocked on before entry. We saw staff offering people meaningful choices. Staff gave us examples of how they treated people respectfully, for example, "I ask what they would like to eat and how I can help." They told us they treated people in a way they would like to be treated if they were receiving the service

The registered manager gave us examples of how people's particular spiritual beliefs were met, for example through providing a communal atmosphere that reflected the current part of that religious calendar. She also told us of the importance of not distressing people using the service, but of trying to find ways of working with them to address personal care needs.

The management team provided two specific examples of the service's caring approach. One person visited for lunch regularly, but if ever they were ill, the service arranged for lunch and support to be provided at their home. One person moved into the service on a temporary basis after their permanent carer fell ill. The provider continued to accommodate this person despite ongoing difficulties with arranging a formal funding arrangement.

The service had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. One staff member told us, "We don't talk about people outside of the home or to anyone else. We keep their information safely." Confidentiality was included in induction and ongoing training and was referred to within the staff handbook.

The management team told us that visitors were welcome at any time with the agreement of the person using the service. The provider's service enabled people to use the service during the day, and so we saw that a few additional people came for lunch.

We noted that, with the exception of the temperature in the service at times, the environment was homely and welcoming. The communal areas had many pictures and items of interest. Most people's rooms were similarly active and reflected them as individuals. The management team told us that an extensive out-house had been recently built at the end of the garden. Its functions included imminent use for afternoon tea for people using the service, and for staff training purposes.

The office manager told us when asked that the service did not advertise any independent advocacy services. In this respect, the service could be doing more to ensure people's views were listened to.

Requires Improvement

Is the service responsive?

Our findings

People told us they had choice and control within the service, for example, in whether to have meals in their rooms or in the lounge. There was equipment such as hand-rails and a passenger lift to enable people to move around more easily. One person explained how the service had arranged for additional equipment to support their independence and safety. People's preferred routines were respected, for example, for when they liked to get up, and for the frequency of night checks. Staff we spoke with emphasized that they always asked people what support they wanted. We heard staff doing this. Staff also showed us that they knew people's individual needs and abilities well.

We found that care plans lacked accurate and complete information to guide staff. One person had specific mental health needs according to information from the office manager; however, there was no care plan for this need. There had been a recently recorded meeting to consider the person's mobility needs; however, despite actions arising from that, there was no record of update in the person's care plan.

In some people's cases, there was more than one care plan providing contradictory guidance for the same issue. For example, one person had care plan guidance stating, "Must be accompanied at all times when walking." A different part of their care plan stated, "Walks on her own." This person was at risk of falls, so contrary guidance could have a negative impact on their safety and welfare.

One person was recorded as having no long-term memory problems, but was also recorded as having difficulty recalling their past. Their recent dependency assessments indicated increasing care needs including identification that the person was now at risk of pressure ulcers. However, they had no plan for pressure care.

The evidence above demonstrates a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records demonstrated some responsiveness to people's changing care needs. For example, one person's care plan had been updated following discussion around their increasing forgetfulness, with an emphasis on staff providing patient support.

The registered manager told us how work had been undertaken to develop more activities and engagement with people using the service. Many activities were based around the Christian ethos such as bible groups, but we also saw people playing dominoes with staff support. The service also had a small dog and a fish-tank, both of which interested some people.

The service had call-bell system equipment but it was not operable. The registered manager explained that the decision to stop using it was because some people with dementia historically had continually used it without need. People instead now used mobile phones to call for staff support where needed, which one person told us worked fine for them.

People and their relatives were invited and encouraged to attend occasional meetings to check their views on the service. The meetings were minuted and people were supported to put their views forward including complaints or concerns.

People and their relatives found the management team to be responsive to them. The registered manager informed us that if people were not happy with the service they were aware that they could contact her, the office manager or a member of the Board of Trustees. The service had a complaints policy in place. It clarified that matters could also be raised with independent authorities if needed. We saw records that provided evidence of the registered manager addressing concerns, albeit the formal complaints record was blank.

Inadequate

Is the service well-led?

Our findings

The registered manager, who had set up the service many years ago, told us she did not manage the service so much on a day to day basis anymore, but lived on the premises and kept up-to-date with changing standards. She had therefore provided the training to staff on the new national Care Certificate, and was always available to advise and support staff on the standards of care to be provided. We noted that the registered manager received an award in 2015 from the local authority for services to the borough. She told us this was primarily in respect of providing the care services.

The office manager provided the day to day leadership. He demonstrated a good knowledge of the specific needs of each person using the service. We saw that he held a national qualification in care management.

Staff told us that they received good support from the management team, that managers were approachable if they had any concerns or questions, and that they were happy working for the provider. One staff member said, "I feel very supported. We do lots of training. If there are problems we can go straight to our manager." There was a whistleblowing procedure that staff said they would be comfortable using, and which records showed evidence of discussion on.
The registered manager confirmed that the staff team worked well together, which was a development from our most recent inspections.

Despite the above, the breaches of regulations that we found during this inspection demonstrated that the oversight of the service was not effective at identifying care delivery risks to people using the service and taking appropriate action in response.

Surveys of the views of people using the service and relatives were sent annually. No report on the findings of these was written. Instead, the management team told us that action was taken in response to individual responses if needed. We saw a number of surveys from early 2015 which provided mainly positive feedback about the service.

The service's incident file contained only a reporting procedure and blank witness statements. It did not contain records of incidents reported to us by the management team. Two recent accidents at night were recorded on an accident/incident form that was on top of loose paperwork on one desk. There were no oversight records of accident and incidents at the service by which to assess, monitor and mitigate risk relating to these occurrences. We were therefore not able to find records of an incident of a flooded bathroom that the office manager told us about. This was not effective operation of a system to ensure compliance with legislation in support of maintaining the health, safety and welfare of people using the service.

There were no specific audits of aspects of the service such as infection control, recruitment or medicines, except for two-monthly health and safety checks written by a senior staff member. However, these did not identify issues for action. Despite stating that the first aid box was checked, the box contained some items that were out of date as far back as 2011. The health and safety check did not identify the disorganized

approach to maintaining accident and incident records.

In particular, we noted that each of the staff files we looked at had an audit sheet at the front with points ticked off to reflect what was in the files. Criminal record disclosures and written references were not ticked off, but no action was taken to address this, and we found cases where these were not in place as required.

One staff member's records showed they were entitled to work in the UK until February 2014. The management team told us they were obtaining updated paperwork to show that the staff member had a current clearance to work, but at the time of drafting this report, a copy had not been provided to us at our request. Another staff member was entitled to work limited hours during term-time, but records indicated they may recently have been working in excess of this. The management team confirmed that they did not have a recorded system of checking the right-to-work status of applicable staff and ensuring they complied with these including any restrictions on hours. This did not demonstrate effective operation of a system to ensure that staff deployed always had current right-to-work status and that any restrictions on that were followed.

We noted that the provider's quality assurance policy set out five systems that assisted with ensuring a high quality of care. These were staff training, staff supervision, regular staff meetings that people using the service could input into, surveys of residents, and registration with CQC. There was no further detail on how these systems would be operated. We noted that whilst staff worked well together during the inspection visit, and they told us of being well supported, documented staff meetings and supervision did not occur on a regular basis.

We were shown an oversight tool used to track that each staff member had received three supervision meetings and an appraisal during the year, in contrast to the annual frequency we were told about. It had not however been updated since 2014.

The office manager told us there were no visits from representatives of the provider, to oversee the quality of the service, only monthly checks of the accounts. A file in the office for trustee visits recorded a last quality auditing visit in 2013. In conjunction with our findings of breached regulations at this inspection, this failed to demonstrate that the provider was operating effective systems to ensure compliance with the relevant legislation in support of delivering high quality care.

We asked the management team what action they had taken as a result of the feedback from a local authority contract monitoring visit in December 2015. The management team could not provide us with any examples, which did not demonstrate effective governance.

We noted that the service's office was not maintained in a tidy manner. The two computer desks and the tops of cabinets were covered in files and papers, albeit some other files were stored tidily on shelves. We found that neither office computer locked to prevent access if left unattended and that records relating to people using the service and service management were therefore accessible. We found that the registered manager had recorded a disciplinary meeting with one staff member for unauthorised access of her computer. The office manager confirmed that the office door was not kept locked when the office was not in use, although we saw that access to paper records about people using the service and staff was secure. Reasonable precautions were not being taken to securely maintain records about people using the service and the management of the service.

We found there to be insufficient records of people's care and the management of the service. We found an accident record from the autumn of 2015 on top of paperwork on one cabinet rather than in the accident

book or the file of the person involved in the accident. The electronic records for this person failed to record in the accident/incident section that they had had an accident. When we asked for health professional records in relation to specific people using the service, we were told that this was within the daily records about that person. There was no oversight or indexing system by which to easily access these records, despite the service's electronic care planning system having a section for this. The office manager told us of recent GP input for one person that resulted in a prescription of antibiotics. However, the GP's involvement was not recorded in the person's care records.

There were no contemporaneous records of checks made of people at night, just a write-up of the overall care each person received at night. Checks of care records for two people showed they were supported to have a bath or shower less frequently than once a week. The management team said this would not be correct in practice, but recognised therefore that the records were not accurate. They explained that recording inaccuracies could be due to language capabilities of different staff. However, there were no quality checks being recorded to address the risk of any such inaccuracies. All of this information failed to demonstrate that records were securely, accurately and contemporaneously maintained in support of operating effective systems to comply with legislation.

The evidence above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection, the provider had notified us of their intention to change the person responsible for supervising the management of service, known as the 'nominated individual.' When we checked this person's personnel file, we found that they had some qualifications and skills for that role, but they were line-managed by the registered manager. This compromised their ability to supervise the management of the service. We also found that they, and the person they were replacing, were not employed as a director, manager or secretary of the provider, as required by legislation, insofar as they were not a member of the Trust's board of trustees. In conjunction with the breach of regulation 17, for good governance of the service, this did not demonstrate that the provider was represented by an appropriate person.

The evidence above demonstrates a breach of regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider last notified us of a death of someone using the service in July 2014. When we checked with the management team if this was accurate, they told us of the death of two people using the service since then. They confirmed that they had not notified us as required. This prevented us from monitoring the service effectively.

The evidence above demonstrates a breach of regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

When we checked the service's accident records, we found that one person had been taken to hospital in the autumn of 2015 following a fall at the service. They had sustained a fractured wrist. Whilst the management team provided evidence of notifying the Health and Safety Executive of this, they confirmed that they had not notified us as required. This also prevented us from monitoring the service effectively.

The evidence above demonstrates a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

In reference to the above fall, the office manager confirmed that there were no investigation records for the

accident by which to show transparency of the facts of the accident, nor plan to minimise the risk of reoccurrence. This did not demonstrate sufficiently open and transparent actions in response to the accident.

The evidence above demonstrates a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In December 2015, we sent the provider a formal request to provide us with some pre-inspection information. A further email was sent later that month after we received no response. We noted that the link in the email was never accessed, and that we did not receive the information requested. Some information we requested during the visit was not ultimately sent. We also failed to receive a response in the summer of 2015 when we emailed a question to the provider in respect of their request to change the name of the person formally representing the provider in correspondence with us. This did not demonstrate a well-led service.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider failed to notify the Commission without delay of the death of two service users. Regulation 16(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission without delay of an injury to a service user that resulted in changes to the structure of the service user's body. Regulation 18(1)(2)(a)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care of service users was not consistently appropriate and did not consistently meet their needs and reflect their preferences. This was because care was not consistently designed with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9(1)(a)(b)(c)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent

Care of service users was not provided with the consent of the relevant person, or where the service user was unable to give such consent because they lacked capacity to do so, in accordance with The Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure that aspects of the premises and equipment were consistently suitable for purpose and properly maintained. Regulation 15 (1)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to act in an open and transparent way with relevant persons in relation to the care of a service user who was involved in a notifiable safety incident. This included failure to provide a written notification to the relevant person and keep a copy of all such correspondence. Regulation 20(1)(4)(5)(6)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 6 HSCA RA Regulations 2014 Requirements where the service provider is a body other than a partnership The provider give notice to the Commission of the name of someone to represent them who was not appropriately employed and who was not responsible for supervising the management of the carrying on of the regulated activity by the provider. Regulation 6(1)(2)(a)(b)

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 Care of service users was not provided in a consistently safe way. This included failure to: assess the risks to the health and safety of service users of receiving care; do all that was reasonably practicable to mitigate any such risks; ensure that the premises are used in a safe way in respect of consistent warmth; ensure the proper and safe management of medicines. Regulation 12(1)(2)(a)(b)(d)(g)

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about their audits of service users' care plans and risk assessments, medicines, and recruitment checks, and what action was being taken to address any risks identified in those audits.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the Fundamental Standards. This included failure to: assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; maintain securely an accurate, complete and contemporaneous record in respect of each service user and in relation to management of the service and staff. Regulation 17(1)(2)(a)(b)(c)(d)(i)(ii)

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about their audits of service users' care plans and risk assessments, medicines, and recruitment checks, and what action was being taken to address any risks identified in those audits.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure that persons employed for the purposes of carrying on a regulated activity were of good character. Recruitment procedures were not operated effectively to ensure that persons employed met the above condition. Where a person employed by the registered person no longer met the above condition, the registered person did not take such action as is necessary and proportionate to ensure compliance with that condition. Regulation 19(1)(a)(c)(3)(a)(5)(a) S3 pts 2-5, 7, 8

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about their audits of service users' care plans and risk assessments, medicines, and recruitment checks, and what action was being taken to address any risks identified in those audits.