Meriden Homes Limited

Hawthorns

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 inspection took place on 12 and 19 December 2015. It was an unannounced inspection. We carried out this inspection following concerns raised with us in relation to leadership and the overall maintenance of the service. When we last inspected this service in October 2015 we found the service was meeting its legal requirements.

The Hawthorns is registered to provide accommodation for people who require nursing or personal care. The home provides accommodation and support for up to six adults who have learning disabilities. It is situated in Minster Lovell near Oxford. On the day of our inspection six people were living at the service.

The service did not have 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 2008 and associated Regulations about how the service is run.

Risks to people were not always managed safely. People were not always protected against the risk associated with the services environment and untoward incidents.

People were not protected against the risk of the spread of infection. Hand washing facilities within two areas of the home did not have hot water available to assist people and staff with maintaining their hygiene.

Medicine administration records were not always accurate. Staff did not receive regular competency checks to ensure they had the correct skills for administering medicines. Medicines were not always stored in line with the manufacturer's guidance.

Staff had completed training in relation to MCA. However, not all staff understood the principles of the Act and how to support people in line with the principles.

Records relating to the recruitment of new staff showed relevant checks were not always completed before staff worked unsupervised at the home. Staff training was not always up to date.

Care records did not always include guidance on how to support people who may demonstrate behaviour that could be seen as challenging to themselves or others.

The provider had not always notified CQC of reportable events. Audits were not conducted to monitor the quality of service.

Equipment relating to the day to day running and management of the service was not always working.

There were sufficient staff to meet people's needs. Staff were not rushed in their duties and had time to chat

with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support. People had access to activities which included range of activities of their choosing.

People had sufficient to eat and drink. Staff who clearly understood the likes and dislikes of the people they were caring for.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question 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.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One breach of the Health and Social Care Act 2008 (Registration) Regulations (2014).You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people were not managed safely. The premises and equipment was not maintained to ensure people were safe.

People were not protected against the risk of the spread of infection.

Medicines were not always stored in line with the manufacturer's guidance.

Records relating to the recruitment of new staff showed relevant checks were not always completed before staff worked unsupervised at the home.

Is the service effective?

Requires Improvement

The service was not always effective. People's care plans did not always contain information guided by the principles of the Mental Capacity Act 2005 (MCA).

People were not always supported by staff who had the skills and knowledge to carry out their roles and responsibilities

People had sufficient to eat and drink and were supported to maintain good health.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records did not included guidance on how to support people who may demonstrate behaviour that could be seen as challenging to themselves or others.

Staff understood people's needs and preferences. Staff were knowledgeable about the support people needed.

There was a range of activities for people to engage with.

Is the service well-led?

Inadequate

The service was not well led. The service did not have a registered manager.

The provider had not always notified CQC of reportable events.

Audits were not conducted to monitor and improve the quality of service.

Equipment relating to the day to day running and management of the service was not always effective.

Hawthorns

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 was 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 inspection took place on 12 December 2016 and 19 December 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we looked at previous inspection reports and notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. This ensured we were addressing any areas of concern.

We spoke with three people, three relatives, six care staff, the manager and the deputy manager. We reviewed four people's care files, six staff records and records relating to the management of the home. Prior to the inspections we spoke to commissioners of the home to get their views how on the service is run.

Inadequate

Is the service safe?

Our findings

We noted that the grounds to the service were not always maintained well in order to keep people safe. For example pathway surfaces adjacent to the access points of the service were cracked, pitted and contained holes. This compromised the safety of both people with mobility difficulties and people's exit routes in the event of an untoward incident. The manager told us that they had requested for this to be addressed by the provider. However, to date no action had been taken. The manager also told us "The pot holes are that bad that they could cause an injury if we have to get out in an emergency". A staff member we spoke with told us "[Person] struggles with the paving slabs. You can't imagine how hard that is for someone who is disabled". We noted that one person's care records stated '[Person] is very unsteady on (their) feet. (Person) is at risk of falling over in or out of the house'.

People were not protected against the risk of the spread of infection. For example, hand washing facilities within two areas of the home did not have hot water available to assist people and staff with maintaining their hygiene. We turned hot water taps on within these areas and noted that after five minutes the water was still cold. We spoke with the manager about this and they informed us that this interruption to the hot water supply had been like this for the last 12 months.

Not all areas of the premises were kept clean, one of the areas of the service which was littered with rubbish and decaying food. We noted that there was a strong unpleasant odour within this area. Prior to entering the room we were informed by staff of the state in which the room was in and that they regularly carried out a deep clean of the area. However, we saw no evidence that a deep clean had taken place for some time evidenced by the decaying food. There were no records within the service to document effective cleaning regimes had been carried out on this area.

People were not always protected from risks associated with the environment. Where people were identified as being at risk, assessments were in place. However, the service had not always done all that was reasonably practicable to mitigate the risks associated with people's care. For example, one person had been assessed as at high risk of falls. However we observed that the flooring within a main corridor of the service was in need of repair. The flooring had cracked and due to an additional issue with the homes central heating the floor had also become uneven. We spoke with the manager about the condition of the flooring and they told us "That could present a trip hazard for people with limited mobility".

This person's care record gave guidance for staff to mitigate the risks associated with falls when the person was carrying out specific activities. However, there was no risk assessment or guidance in place to mitigate the risks associated with their living environment.
This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected against the risk associated with the services environment and untoward incidents. Due to concerns raised at the inspection in relation to fire safety the Care Quality commission made an immediate referral with Oxfordshire Fire & Rescue Service. Subsequently the service was visited the

following day by fire safety officers. One of the findings from this visit was that the service's fire risk assessment was outdated and inadequate.

Medicine administration records for one person demonstrated that they had missed their medication for one day. This was because the person had gone out for the day. The service had not made arrangements for the person to take their medication with them. This practice was not in line with the provider's medication policy that stated 'if (service user) is expected to be (or even if he/she may be) out of the building when a drug is to be given, the days nominated drugs administrator must place the necessary drugs in a labelled dosage box'. The service took action by contacting healthcare professional to establish if there was any immediate risks associated with this person missing their medication. However, we also noted that the staff member responsible for the administration of medication on this day had not had a medication competency check carried out by their seniors. The manager and the deputy manager informed us that medication competencies should be checked every three to six months. However, we could find no record that this had been carried out for this staff member. We noted that staff had then administered this medication on a different day. Therefore the dossett box which contained the medication for this person did not align to the MAR in that it demonstrated that this medication had been received. The staff team then used the medication for consecutive days. This presented an inaccurate record of when this person's medicine was missed. The impact of this was that this practice increased the risks of a drug error occurring.

Medicines were not always stored in line with the manufacturer's guidance. For example one person's medicine gave clear guidance that the medicine 'should be discarded three months after opening'. The guidance also stated that the date in which the medicine was first opened should be recorded on the space available on the packaging. However, this space was blank and the date of opening had not been recorded anywhere on the medicine or within medicine records. We noted that another person's medicine that required the recording of an opening date had not had this completed. The manager and the deputy manager confirmed that these dates had not been recorded. We looked at the guidance for five medicines that were required to be stored within certain temperatures. However, the service had not recorded the temperatures within the medication room. Therefore we had no way of knowing if safe temperature parameters had been exceeded. We spoke with the manager about this and they told us that this used to take place. However, this practice had stopped.

Following our inspection we wrote to the provider asking them what immediate action they were taking to ensure that the homes fire risk assessment was updated. The provider had arranged for this to be carried out by an independent company. This was carried out. However, the service had been without an adequate fire risk assessment for a significant period.

We also asked the provider what immediate action they were taking to address the environmental risk surrounding the trip hazard. The provider wrote back to us stating that a company had been booked to come in and affect repairs in January 2017. However, this significant risk had been present for a significant period.

The provider told us that reasonable steps were being taken to ensure that staff were up to date with their competencies checks in relation to the administration of medicines. However, an absence of a mechanism to ensure staff had the correct skills set had compromised the safety of people using the service.

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

Records relating to the recruitment of new staff showed relevant checks were not always completed before

staff worked unsupervised at the home. These checks include employment references and Disclosure and Barring Service checks (DBS). These checks identify if prospective staff were of good character and were suitable for their role. We noted that people working within the service had not received the satisfactory checks that were in line with the provider's recruitment policy. The policy stated that 'no candidate may commence employment until' the satisfactory checks had been received by the provider. These satisfactory checks included two references and a police background check. We noted that the provider had only received one reference for two of its staff.

Another staff member's file contained no evidence that reference requests had been sought. We also noted a staff member's DBS had not been verified by the provider prior to the person working in the service. Another staff member file did not evidence that a DBS had been requested. We spoke with the manager about this staff file and they told us, "I sent it Thursday, Friday last week". The manager also told us "It's been a bit hit and miss (in relation to DBS), I think it was something to do with the account. Once there was some money in the account so I pushed a load through. But we sent some off recently and I have not heard anything". We asked the manager what action had been taken to mitigate the risks associated with these recruitment concerns. For example, if any staff risk assessments had been carried out by the service. However, the manager informed us that no action had been taken.

Following our inspection we wrote to the provider asking them what immediate action they were taking to ensure that staff had undergone satisfactory checks to ensure they are of good character and suitable for their role. The provider gave reassurances that this was being addressed. However, this was not in place at the time of our inspection.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people who lived in the service had communication difficulties and were unable to tell us if they felt safe living residing at the Hawthorns. However, we watched people interact with staff and saw that they were at ease with them. We observed interactions that demonstrated that people had put their trust in the staff to look after them safely.

People were supported by staff who could explain how they would recognise and report abuse. One staff member we spoke with described to different types of abuse. Staff comments included; "I would report any concerns to my manager", "I would inform my seniors immediately" and "I would go to my manager or [provider]". Staff we spoke with told us they would report concerns immediately.

Staff were also aware they could report externally if needed. Comments included; "If I felt that someone was in immediate danger then I would call 999", "I would contact the safeguarding team" and "I would contact CQC (Care Quality Commission)".

There were sufficient staffing levels. We looked at three months of staffing rotas which evidenced there were enough staff to meet people's needs. Relatives told us there were enough staff to meet people's needs. One relative said, "When I visit there seems to be enough staff". We saw evidence that staffing levels were regularly reviewed by the management team. During the day we observed staff were not rushed in their duties and had time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support.

Requires Improvement

Is the service effective?

Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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.

Staff had completed training in relation to MCA. However, not all staff understood the principles of the Act and how to support people in line with the principles. For example, staff were able to explain how they would give people choices and how they would respect people's decisions to decline support. However, staff did not understand their responsibilities in relation to making best interest decisions on behalf of a person who had been assessed as lacking capacity to make a specific decision.

People's care plans did not always contain up to date information that was guided by the principles of the MCA. Care plans did not always contain clear information relating to people's capacity to consent to care. For example, one person's care record contained a mental capacity assessment that had been completed by another service prior to the person moving to the Hawthorns. This assessment and the person's care records did not specify the specific decisions the capacity assessment related to. One person's risk assessment highlighted the person lacked capacity to manage their finances. However, this person's care record did not contain a mental capacity assessment or details of a best interest process in relation to the management of the person's money.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were assessed as being at high risk of weight loss had accurate and up to date records in place. Staff we spoke with told us they were aware of these risks and what action to take as a result. However, one person's care records did not evidence that staff had taken the appropriate action to mitigate the risks of excessive weight loss. For example, this person's care record highlighted that the person had lost 10lb in one month. The manager and the deputy manager informed us that appropriate communication had taken place between the service and healthcare professionals. However, this person's care record did not evidence what action had been taken. We spoke with the manager about this and they told us "It's happening we are just not recording it". The deputy manager told us "We are not showing what we are doing about it". We saw this person and they appeared to be in good health, therefore we were satisfied that this concern related to poor record keeping.

Staff told us they received an induction and completed training when they started working at the service. The service used an induction checklist to ensure that staff competencies were demonstrated prior to staff working unsupervised. However, we noted that these checklists were not always accurate. For example, one new member of staff had been recorded as being booked onto 'physical intervention training'. However,

training records confirmed that this training had not been available to staff since December 2015. We spoke with this staff member who confirmed that this training had not been offered to them.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training that included health and safety, epilepsy awareness, safeguarding, moving and handling, medication and infection control. However, people were not always supported by staff who had the skills and knowledge to carry out their roles and responsibilities. This was because staff training was not always up to date and in line with the provider's policy. For example, we noted that training in relation to fire awareness and physical intervention training was out of date.

Staff told us they received an induction when they started working at the service. Feedback from staff about the induction was varied. Comments included, "It was O.K. but it could have been more in depth", "It felt rushed and then it was a case of just picking things up", "It was pretty full on and there was a lot to take in" and "Yeah it was alright".

Staff told us, and records confirmed they had effective support. Staff received regular supervision (one to one meetings with their manager). Staff we spoke with told they felt supported by the manager and the deputy manager. Comments included; "They are absolutely brilliant. They are open and honest", "I feel really supported" and "It's a good team, the staff have so much respect for [manager] and [deputy manager]. There is a team gel". Records showed staff also had access to development opportunities. For example national qualifications in care. One staff member we spoke with told us "I have just signed up for my (National qualification)".

People had sufficient to eat and drink. Care records showed people's choices and preferences were identified and recorded. People who needed assistance with eating and drinking were supported appropriately. During our observation of the lunch time meal we noted that people were offered a choice of drinks throughout the meal and had access to, and were offered drinks throughout the day. Staff clearly understood the likes and dislikes of the people they were catering for.

People had regular access to other healthcare professionals such as, G.P's and occupational therapists.

Good

Is the service caring?

Our findings

The majority of people who lived in the service had communication difficulties and were unable to tell us if they felt that they benefited from caring relationships with staff. However, we watched staff interact with people. We observed positive interactions that demonstrated that people had positive relationships with staff.

Relatives we spoke with told us, "They do a fantastic job there" and "[Person] is happy and cared for".

Staff spoke with people in a warm, respectful and patient manner. Staff listened to what people were saying and gave them time to express themselves. For example, one person who had difficulties communicating informed staff of an activity that they were looking forward to. The staff member showed patience in allowing this person to fully describe and express the activity before asking them some more questions. This person was clearly enjoying the interaction with the staff member.

Throughout our visit we saw people were treated in a caring and kind way. The staff were friendly, polite and respectful when providing support to people. Staff took time to speak with people and reassure them, always making sure people were comfortable and had everything they needed before moving away. For example, one person had a cough whilst they were eating their lunch time meal. A staff member went to support this person. The staff member knelt down to the person's eye level and made sure they were alright before offering the person a drink. The person refused and staff respected this person's choice. The staff member then kept a watchful eye over the person whilst they finished their meal.

People were treated with dignity and respect. Staff took time to ensure people understood what was going to happen and explained what they were doing whenever they supported people. For example, we observed one person who was at risk of falls being supported to transfer to a walking aid. Throughout the interaction the staff member kept the person updated on what they were doing and what they were going to do next.

Relatives told us people were treated with dignity and respect. One relative told us "They are doing a great job there, they treat him with dignity". Another relative told us "They respect people as individuals".

Staff we spoke with told us the importance of informing people of what was going to happen during care. One staff member said "It keeps us and the service users safe". Another staff member told us "We treat people in the way that we would want to be treated". When staff spoke about people to us or amongst themselves they were respectful. People's friends and relatives could visit whenever they wanted to.

We asked staff how they promoted people's dignity and respect. Staff comments included "We keep the doors closed and curtains shut", "During personal care it's important we keep people covered up as much as possible and not expose them", "It's also important that we keep paper work and I always pop a towel over them. We respect choice you always have to give a choice". We saw staff knocking on doors that were closed. When they provided personal care, people's doors and curtains were closed.

Staff we spoke with told us how they supported people to do as much as they could for themselves and recognised the importance of promoting people's independence. One staff member told us "We need to promote independence as it is important. We can promote this by encouraging people to do day to day tasks such as cooking and personal care". Another staff member said "We encourage people to do the activities they like to do. This helps build up people's confidence".

Information relating to people and their care was held in the office. The office had a keypad door lock ensuring people's information remained confidential.

Relatives told us that people were involved in their care. One relative told us "Oh yes [person] is very much involved in their care". Another relative said "They involve [person] as much as they can". Staff understood the importance of ensuring that people were involved in their care. One staff member told us "It's about recognising individual needs and treating people as individuals".

People had their own rooms which enabled them to maintain their privacy. Staff we spoke with told us people were encouraged to personalise their rooms. Every person's room had been personalised and made to look homely. A staff member we spoke with told us "At the end of the day it's their room and we should be supporting them to have it in a way they want to".

Requires Improvement

Is the service responsive?

Our findings

Some care records included guidance on how to support people who may demonstrate behaviour that could be seen as challenging to themselves or others. For example, two people's care records highlighted signs and behaviours that indicated they were becoming agitated. This guidance also included de-escalation techniques that could be used to manage this behaviour. However, one person had been identified as at high risk of presenting behaviours that may challenge others did not have the appropriate guidance in place for staff. This person's risk assessment highlighted 'staff need to recognise the evaluation of (behaviour) and attempt to engage redirection techniques and strategies to avoid further escalation and potential for (behaviour)'. However, this persons care records did not contain guidance for staff on evaluating the person's behaviour and what redirection techniques and strategies should be used. From speaking to staff we were confident that this concern related to record keeping and not staffs knowledge on what action to take to mitigate the risks associated with this person behaviour.

The manager informed us that the service sought people's views and opinions. They told us that service user meetings took place "Once a month". However, there was no evidence or record that this had taken place. In the absence of a recording system the service could not demonstrate how information and experience within the service had been responded to properly. Therefore the service could not demonstrate any improvements that had been made following feedback from people.

People's needs were assessed prior to admission to the service to ensure the service could meet their needs. Prior to moving into the home people were encouraged to visit. However we noted that one person's care record did not contain an assessment of needs. We raised this with the manager and the deputy manager and they were able to eventually find this in paperwork. We noted that this record was in a different file that was not related to the person's care record.

Relatives told us the service was responsive. One relative told us "They always ring if there is a problem". Another relative told us "They respond to any concerns".

Care records contained details of people's medical histories, allergies and on-going conditions. Care plans had been developed from the information people provided during the assessment process. Care plans were updated regularly to ensure the information was accurate.
Staff were responsive to people's changing needs. We noted the service had responded to one person's changing needs surrounding there medication. Following this change in need the home liaised with healthcare professionals to ensure that appropriate monitoring of this persons health was in place to mitigate any side effects of the medication. This meant the person's needs were continually assessed.

People's care records contained a 'hospital passport'. These documents contained important information about people that could be passed to professionals in the event of an emergency or healthcare appointment. For example, one person's ''hospital passport' contained guidance on the person's communication styles on how they would express pain or anxiety. This guidance also included actions that professional could take to help ease the persons anxiety of being in an unfamiliar setting.

People received personalised care. All the care plans held personal information about people including their care needs, likes, dislikes and preferences. Staff we spoke with knew the people they cared for. For example, we spoke with one staff member about a person they supported they were able to tell us the person's likes, dislikes and preferences that matched those outlined in the person's care records. Staff we spoke with were able to tell us people's preferences in relation to their care. For example, one staff member explained the importance of following a person's set routine when delivering personal care.

People had access to activities which included range of activities of their choosing. These activities included that puzzles, art and crafts and holidays to people's preferred sea side resorts. Activities were seen as the remit of all staff. Throughout the home we saw pictures of people enjoying activities that they had been on. One relative we spoke with told us, "[Person] is looking forward to Christmas because the staff there make such a big thing of it. It's brilliant she loves it".

The manager told us and records confirmed that had been no complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

The provider did not an effective system in place to monitor the quality of service. The manager did not routinely monitor the quality of service provided. The manager told us that records about people's care were checked, as were medicine records. However, the manager could not provide any evidence that a system to monitor processes and practices within the service was in place. This meant that the provider could not identify patterns and trends that would allow them to improve the service.

The manager had not identified our concerns we found during this inspection. An effective system would have identified the concerns that we had raised during the inspection in relation to infection control, safe storage of medication, care records, MCA, staff induction, safe recruitment practices, healthcare referrals and risk management.

During our inspection we noted that the service's policies and procedures were outdated. For example, the recruitment policy referred to POVA (Protection of vulnerable adults) checks. This was replaced by CRB (Criminal Records Bureau) which has now been replaced by DBS (Disclosure and Barring Service). We also noted that the policies and procedures referred to another service that the provider no longer owned.

Following our inspection we wrote to the provider asking them what immediate action they were taking to ensure that effective systems were established and put in place. The provider gave reassurances that they had appointed a consultant to audit the quality of their service and support the manager. However, the service had been without an effective quality monitoring system for a significant period of time.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Equipment relating to the day to day running and management of the service was not always effective. For example, during our inspection it was raised with us by staff that the service did not have access to broad band. We followed this up following our inspection on 11 January 2017 and we were informed that the home was still without broadband. The impact of this was that the manager had to go home to check their emails. This also impacted on the manager's ability to raise statutory notifications with the CQC.

We noted that there was a book kept within the home for reporting faults. However, the last entry was in May 2016 and there was no record of the concerns in relation to the heating or hot water. We also checked the staff communication book. However, there was no entry between March to December 2016 in relation to these concerns. The manager told us, "(maintenance staff)] use to do regular maintenance checks but left, we got a new maintenance man two months ago but we were without one since April (2016)".

We spoke with staff about the interruption to the telephone lines and they told us "They cut the phones off completely. They were off for a few good weeks" and "We had to use our own phones". The manager told us "I had the bailiff's here one afternoon. The electric bill hadn't been paid. This really effected [person].

[Person] does not like authority figures".

One staff member described to us how this interruption to the service had impacted on their relative. They told us "I've been trying to get hold of you all day I have been worried". Another staff member described the negative impact that this had on a person as they were once not able to make a weekly call to a relative.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The provider had not always notified CQC of reportable events. For example, we found two notifiable events that included interruptions to the service. This included an interruption to the use of telephone lines. These events lasted more than 24 hours and impacted on the service's ability to carry out the regulated activity. Therefore the CQC should have been notified of these events.

Following our inspection we wrote to the provider asking them what immediate action they were taking to ensure that the Care Quality Commission would be is notified of future notifiable events. The provider gave their reassurances that this would be addressed. However, this was not addressed at the time of our inspection.

This concern is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations (2014).

The service did not have 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 2008 and associated Regulations about how the service is run.

The absence of a registered manager was noted on our last inspection on 15 December 2015 and we were given assurances that an application would be made in order for the provider to fulfil their conditions of the service's registration. Further to this we contacted the provider on 22 November 2016 and requested an update on what was being done by the provider to ensure a registered manager was in post. We were informed by the provider that an application would be submitted by the manager within seven days. However, no application has been received.

The manager had carried out an exercise with staff to identify the levels of stress within the team. This 'stress tool' highlighted that there were staff members who were scoring high and at risk of stress related issues. However, the manager had not followed up this feedback and there was no record of action taken following the results from staff. The impact of this was that no action had been taken to mitigate the risks associated with staff wellbeing.

Accidents and incidents were recorded and investigated. For example, we saw evidence of how the manager had acted swiftly on a concern raised by another member of staff and took the appropriate action. The manager shared with us their learning and how they could mitigate future risks to people using the service.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice.

There was a positive and open culture in the home between staff, the management team and people. The manager was available and approachable. People knew who the manager was and we saw people and staff approach and talk with them in an open and trusting manner.

The service worked in partnership with visiting agencies, particularly the NHS and local authority. The service had links with local learning disability teams and with the local community.