Eton Care Ltd

Hornbeam House

Inspection report

Hornbeam
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Tel: 01923628628

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 31 January 2018 and was unannounced. This was the first inspection of the service since it had been registered in November 2017.

Hornbeam House is a residential home for up to three people with learning disabilities. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection two people were living at the service.

The provider, Eton Care Limited, is a private organisation and the owner is the nominated individual. Eton Care currently has two locations in London.

There was a registered manager in post. 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.

At this inspection we rated the service Requires Improvement in the key questions of Effective, Responsive, Well-Led and overall. It was rated Inadequate in Safe and Good in Caring.

During the inspection on 31 January 2018 we found the provider did not always have systems to keep people safe and mitigate risks. Policies and procedures were not clear about the action staff needed to take. Safeguarding records did not have details of the investigation, outcomes or analysis. Incidents and accidents were recorded on ABC (Antecedent-Behaviour-Consequence) charts but were not logged at a single point or analysed. There were no records for fire safety checks completed or personal emergency evacuation plans (PEEPs) to help protect people in the event of a fire. Medicines audits and medicines competency assessments were not completed. This meant the risks to people's wellbeing and safety had not always been assessed and the risks minimised.

The provider did not always comply with the Mental Capacity Act 2005 (MCA) principles but care workers were responsive to people's individual needs and preferences. However there was no indication that people's end of life wishes had been considered as part of the care planning.

The complaints policy and procedures were not up to date. These and the complaints form were not provided in a format that met people's communication needs.

The registered manager was currently recruiting but at the time of the inspection, there were no permanent care workers. As care workers were agency staff the registered manager did not undertake supervisions or appraisals but had introduced an induction checklist and work book. Care workers undertook training with their agency and felt they had the skills and support to carry out their role competently.

The care plans were written in a person centred manner with clear guidelines and easy read pictures but we did not see any pre-admission assessment records. There was also a lack of written evidence to record that support plans were developed and reviewed with people and their families.

Care workers we spoke with knew how to respond to safeguarding concerns and incidents and accidents. The provider had checks in place to ensure care workers were suitable to work with the people using the service.

There were detailed risk assessments to address some of the risks people faced and risk management plans to mitigate identified risks.

People's dietary and health needs had been assessed and recorded and were monitored to make sure these were met.

The home's environment met the needs of the people using the service. It was clean and care workers knew about infection control procedures to help prevent infections.

People indicated they were happy at the service and care workers knew peoples' likes and dislikes and what their routines were. Families were welcome to visit.

Care workers felt the registered manager was competent and listened to their concerns.

We found six breaches of Regulations during the inspection. These were in respect of safe care and treatment, safeguarding service users from abuse and improper treatment, consent to care, acting on complaints, staffing and good governance. You can see what action we told the provider to take at the back of the full version of the 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.

Safeguarding alerts did not have a record of investigation or analysis to help monitor incidents and allegations of abuse and to record the outcomes of any investigations so learning took place.

There was a procedure in place for the management of incidents and accidents which were recorded in people's files but these were not logged at a single point to provide an overview of the concerns.

People had risk assessments and risk management plans to minimise the risk of harm, but there were no personal emergency evacuation plans (PEEPs) or recorded checks regarding fire safety.

The provider did not always follow safe management procedures for medicines.

The service did not have any permanent care workers which meant people using the service did not have the same care workers consistently providing support.

Care workers knew how to respond to safeguarding concerns.

Profiles for agency staff that indicated safe recruitment procedures had been followed.

The provider was updating their infection control policy and care workers were aware of the risk of infection. The environment was clean and free of hazards.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent to care was not always sought in line with the principles of the Mental Capacity Act 2005.

We did not see a record of people's needs being assessed prior to

moving to the service.

Care workers received an induction but did not receive supervision and appraisals so that they were appropriately supported in their roles.

People's nutritional needs and dietary requirements were assessed and care workers knew how to support people to maintain good health.

Is the service caring?

Good

The service was caring.

People said care workers treated them kindly and with respect.

People were involved with making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was not always evidence of complaints being recorded and used to improve the service.

People and their families were informally involved in planning people's care but this had not been recorded. Neither people nor their relatives were consulted about end of life care.

Care plans included people's preferences and guidance on how they would like their care delivered.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided. However these systems and checks were not always effective in improving the quality of the service people received.

All stakeholders told us the registered manager was approachable and listened to concerns.

Hornbeam 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.

The inspection took place on 31 January 2018 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding and commissioning teams to gather information about their views of the service.

During the inspection we spoke with two people using the service, the registered manager and two care workers. We observed the care and support being delivered to help us understand people's experiences of using the service. We viewed the care records of two people using the service and seven agency care workers files that included recruitment and training records. We also looked at medicines management for two people who used the service and records relating to the management of the service including service checks and audits. After the inspection we spoke with two relatives and one healthcare professional.

Inadequate

Is the service safe?

Our findings

During the inspection we saw the provider did not always have working safeguarding systems and processes to protect people from abuse The safeguarding policy was located under the headings 'Regulation 12 safeguarding for missing persons' and 'Regulation 13 for safeguarding service users from abuse or harm: physical intervention and restraint policy', but there were no clear safeguarding adults guidelines or pathways that helped staff to identify the types of abuse and what to do including who to contact if they had a safeguarding concern.

There had been two safeguarding incidents in the last year. Both were raised through the local authority by relatives. The registered manager was not aware at the time of the first safeguarding in August 2017 that they were required to notify the Care Quality Commission (CQC) of safeguarding alerts, but did notify CQC of the November 2017 alert. The safeguarding incidents were not logged at a central point and there was no record of an investigation. The only audit trail was the emails between the registered manager and the local authority. This meant there were no proper systems in place to help monitor incidents and allegations of abuse that had been reported, and to record the outcomes of any investigations so learning took place.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a standard incident and accident record book but it was empty. When we asked the registered manager about incidents involving people who behaved in a way that challenged the service, they told us these were recorded on ABC (Antecedent-Behaviour-Consequence) forms. We saw ABC forms were in use in people's files and not logged anywhere collectively which meant there was no overview of trends and patterns in behaviour. Additionally there was no analysis or lessons learned recorded to indicate steps taken to prevent re-occurrence

The service had no access to one person's finances which were managed solely by the family. For another person the family also managed their finances but the provider had access to one of the person's bank accounts. Monies held on behalf of people were stored securely and there was money in and out ledger with receipts but the ledger was not up to date, which meant we could not be sure people's money was managed safely.

There were no records for fire safety checks completed as part of ensuring a safe environment. People using the service did not have personal emergency evacuation plans (PEEPs) or complete fire evacuation drills. The fire risk assessment had the name of another service on it and was dated 2015/2016. The registered manager told us the maintenance person checked the fire alarm system but this was not recorded. The gas safety certificate we saw was from 2015. Nor did the provider have a contingency plan for how to manage local emergencies. Therefore we could not be sure people were living in a safe environment.

We looked at medicines administration records (MARs) and reconciled medicines for two people including one who used controlled drugs. Controlled drugs were stored safely but the book to record the

administration of controlled drugs had just been purchased and was not yet up to date. One person had their medicines delivered weekly by the pharmacy and the other person's family managed all their medicines and brought it to the home. Medicines were stored safely in locked cupboards at the correct temperature. We saw individual PRN (as required) medicines protocols. The MAR charts had relevant information such as allergies and medicines were correctly signed for, although one person's MAR chart was very small and difficult to read. We saw the medicines policy was out of date and the staff signature sheet to identify who had initialled the MAR charts was not up to date. Medicines delivered were recorded for one person but not the other. The registered manager was not undertaking a stock check and we saw stock for one medicine no longer in use which the registered manager said they would return to the pharmacy by the end of the week. Medicines audits had not been completed since October 2017. The registered manager said they would start these weekly audits again and incorporate a stock take into the checks.

Care workers had completed medicines training with their agency and told us medicines training was part of their induction. One care worker who had been with the service for a year, said the registered manager had undertaken medicines competency testing, however the registered manager did not have a written record of competency assessments and noted as they were based at the service, which was small, they were continually observing medicines administration. However, based on the evidence we saw, we could not be sure people were receiving their medicines as prescribed and in a safe manner.

The above paragraphs are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since opening, the home had only employed agency care workers. Relatives were not satisfied with this and commented, "[Person] needs stability and continuity. Staff coming and going have an impact [on them]", "The staff are all agency and there is no consistency" and "[Person] should have an additional 12 hours per week in the community. That hasn't happened [due to staffing]." Care workers we spoke with commented, "It would improve if they could have their own [permanent] staff" and "It's agency and it would be better to have people who work here all the time."

People using the service had one to one support in the home and two to one support in the community. We saw there was one male and one female care worker during the day for one to ones and one waking night and one sleep in. One relative told us they were concerned about weekend support as although there were always two care workers on duty, sometimes the care worker providing the one to one support did not know their family member and the relative felt it would be more appropriate for a manager, who did know their family member, to also be present.

The registered manager was always on call, and told us once they have permanent staff, they planned to appoint a senior or deputy manager to share the on call with. That there was not always enough staff for community activities was acknowledged by the registered manager and they had already appointed a part time care worker who was starting in February 2018 as the second care worker required to support people in the community. They were also advertising for permanent care workers. However, the lack of permanent care workers up to the time of the inspection meant there was a lack of consistency that had a direct impact on people using the service as there was not always enough staff available to support people in the community and there was a high staff turnover within the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers we spoke with said they had completed safeguarding adults training with their agency. They

were able to identify the types of abuse and knew how to respond to safeguarding concerns. They told us, "I would assess and then involve the management. I would contact the local authority safeguarding team," "First I would talk to the manager and if they don't give a concrete response, the CQC" and "Whistleblowing is if you see a situation of concern, you have to inform the relevant authorities." A relative told us, "We have never had a concern around safety."

Care workers also knew how to respond to incidents and accidents and one care worker said, "With an incident or accident, I first and foremost inform my manager. Depending on the nature of the incident, I will call the ambulance."

The provider had systems in place to ensure agency care workers were suitable to work with people using the service. For the seven regular agency staff working at the service, we saw profiles from the care agency confirming the care workers' criminal record checks, eligibility to work in the UK and their training.

There was evidence of detailed risk assessments and there were measures in place to minimise identified risks for areas that included eating and personal care. Risk assessments included the potential risk, the trigger points or precursor behaviour, a proactive strategy to prevent an incident, the risk level and the reactive strategy with guidelines for what to do if the incident occurred, future expectations and additional comments. Risk assessment gave clear instructions for how to avoid triggers and how to respond. We saw that one person had a risk strategy for choking and observed them during lunch. The care worker supporting the person followed the guidelines as per the risk management plan. This indicated care workers understood the risks to people and the action to take to mitigate them.

There were some checks to ensure the environment was safe. A daily checklist looked at a number of points including, fridge, freezer and the medicines cupboard temperatures, a clean environment, secure doors and windows and perishable foods. We also saw a weekly environment checklist with comments.

The infection control policy was out of date but was in the process of being updated. Care workers had undertaken infection control training through their agency in the last year and said, "For infection control we use gloves and aprons" and "Anytime I am doing anything like a shower, I use gloves and aprons." We saw care workers also used gloves and aprons when preparing meals. We observed the service to be clean and fresh throughout and a relative told us, "It's always clean."

Requires Improvement

Is the service effective?

Our findings

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider was not always working within the principles of the MCA. We saw a policy titled 'Regulation 11– need for consent' but this was about consent to medical and dental treatment and did not include consent to care. When we asked care workers if they sought people's consent when providing them with care, they told us, "I have to do my work in a relevant way so it is not intrusive. We have to talk things through before we do it. If [person] doesn't want her hair washed, I have to use language to persuade them. We offer a range of clothes and shoes and they choose what they want they want to wear."

One care workers said they had completed MCA training two years ago and the other care worker said it had been included in other training courses they had completed. Neither care worker knew if the people using the service had DoLS authorisations. Both people using the service had expired DoLS authorisations as new DoLS applications had been submitted three days before the old ones expired.

The registered manager believed one person's relative had lasting power of attorney (LPA) for both health and welfare, and finance but there was no evidence of this on their file. They did not know if the other person's family had LPA for them.

We saw one person had a PRN protocol from the local authority which recorded 'PRN given in [person's] best interests as they lack capacity', signed by the psychiatrist and nurse but not dated. Both people using the service had the statement in their support plans, 'I do not possess financial capacity and therefore all decisions are made for me by my parents' but there was no evidence of a best interests decision or the parents' having lasting power of attorney. Additionally, one person's parents were not the relative making their decisions.

One person's file had a document that stated, 'In making a best interests decision I agree to the information contained within this document' but it was not clear what the best interests decision was for and it was not dated or signed. Therefore neither person's support plan had information indicating if they had the capacity to consent to their care. There was also a lack of evidence to show that best interests decisions were being made for their benefit and of lasting power of attorney being in place where the staff believed this was the case. This meant people were not appropriately supported to have their views taken in to account when

decisions about their care were being made and there was no evidence that the best interests process was being followed where the person did not have the mental capacity to make decisions.

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

There were no records to show that people's needs were assessed prior to moving to the service, so the provider could make a decision that the service was able to meet people's needs. However the support plans and risk assessments included assessments of people's care needs and how to support them. A relative we spoke with said they had been involved in care planning.

When we asked if people were supported by care workers that had the appropriate skills and experience to provide a good level of care, relatives provided a mixed response. One relative said they did not think the care workers had a good understanding of their relative's autistic traits and how to manage them. They also felt care workers had not read the care plans for guidance on this, but another relative told us, "Even though there has been a turnover of staff, I cannot speak highly enough of them [care workers]. They are competent and caring." The care workers we spoke with said the agency had provided them with relevant training, which we saw in their profiles, and they felt they had the skills to care for people in the home. Comments included, "I am confident [I have the support and training to do my job]" and "I have the training but the field can be different. The more we work with residents, the better I know them."

All agency staff had safeguarding adults, infection control and medicines training in 2017 but there was no record of Mental Capacity Act 2005 training included .The registered manager had recently introduced an induction check list and a workbook of people's individual needs which agency care workers were required to complete to become familiar with the care and support needs of the people using the service. The care workers we spoke with told us they had induction to the service. One said, "It was chaotic because the person who inducted me [another agency worker], did not know what they were doing. I complained. Now it is quite different since [current registered manager] has put something in place." Care workers had two daily handovers to share information and ensure they delivered effective care to people using the service.

All care workers were agency care workers and were not provided with formal supervision or appraisals. We discussed with the registered manager, that as the agency staff are the only care workers and some are long term, supervision may be a useful tool in supporting them to develop the skills required to care for the people using the service. The registered manager said as they were always present on site there were ongoing informal conversations. However when permanent care workers are employed, they will receive supervisions and annual appraisals.

People were supported to have a balanced and nutritional diet and people we spoke with indicated they liked the food in the home. We saw a suggested four week menu in the dining room but care workers told us people could ask for what they wanted and as there were only two people, this could be accommodated. Care workers said, "At mealtimes we ask what they would like and [the registered manager] does the weekly menu" and "They can help themselves to drinks or snacks. They will ask for them." We observed people having a cooked lunch, being able to sit where they chose to, to eat lunch and care workers supporting them with lunch.

One person had a specific diet and we saw clear instructions of how to support them with this including a check list that was completed at the end of each day. Care workers said, "[Person] is strictly [health concern]. They don't eat any [specific] products. We sanitise everything. They have their own toaster, cupboard and fridge" and "One person is [type of diet] so we know when cooking to never mix things." One

relative said they were not confident all care workers knew how to cook food as their relative would like it, but another relative said, "[Person] has a good variety of food and has never looked fitter or healthier. [Person] can say what they do and don't like. Staff take them shopping."

The provider communicated effectively with other services. For example, we saw information that indicated the service communicated with local authorities and healthcare professionals so people received the care they required.

We saw evidence that people's day-to-day health needs were being met. One person's family preferred to manage all their medicines and medical appointments. Support plans provided a description of people's medical needs and how to support them. When required, weight records were maintained to monitor people's weight so appropriate action could be taken to support people where indicated. Care workers knew how to respond if someone was unwell and told us, "If a service user is unwell, I inform the manager and call the doctor" and "If someone is unwell we talk to the management. If an emergency we call the ambulance but if they can wait until tomorrow, we book a GP appointment."

The home's environment met the needs of the people using the service. For example we saw in response to one person' health needs, people had separate fridges and cupboards which were clearly labelled. Windows had restrictors and there was a locked utility room with the washing machine, dryer and cleaning materials. There was enough space in the home for people to do activities of their choosing or to have space to meet with visitors, including a large garden. The home had begun to equip a sensory room and people's rooms were furnished and decorated according to their individual needs and tastes. A relative said, "[Person] likes living there. Plenty of space which is important for them."

Good

Is the service caring?

Our findings

People indicated they were happy living in the home. A relative told us, "[Person] says they love the house." We observed that people were treated kindly and spoken with respectfully. For example we saw a care worker ask one person if it was okay if they went into the person's fridge. A healthcare professional said they were "impressed" by staff as "clients are well respected and staff engage well with them."

The people using the service had one to one support and care workers were attentive and interacted with people. There were ongoing comfortable conversations among care workers and people which indicated care workers knew peoples' likes and dislikes and what their routines were. We saw balloons and cards from a birthday party held for one person the week before, and we were told the food at the party met the person's specific dietary needs. We observed people in the lounge singing to culturally appropriate songs and one person brought their guitar into the lounge to sing along.

To meet people's individual needs, staff told us, "We communicate with them and check their daily planner." We saw that people could choose where they wanted to sit at lunchtime and care workers supported that. Care workers spoke with the people throughout lunch and were encouraging and supportive in ensuring people's support plan and guidelines for lunch were followed. After lunch one person was encouraged to take their plate to the kitchen and put their rubbish in the bin as part of maintaining their independent living skills.

Care workers were respectful of people's wishes when supporting them with personal care. A relative told us, "Staff are totally respectful. [Person] is always bathed and well turned out impeccably." One care worker described supporting a person with personal care as, "[Person] has a routine. We have to interact a lot. We do a lot of ground preparation. They like background music and to chat with staff. The doors are secure and the windows closed for privacy." Other comments included, "With personal care, always use gloves and aprons. You need to talk to the person and make them feel comfortable and always ask them nicely. Close the door and use a dressing gown for them so they can go to their room [from the bathroom] and get changed" and "We ask [person] what they want to wear. We open the wardrobe and ask them what colour. We encourage them to dress up."

In the provider's advocacy policy it stated, 'We make available information about advocacy…' but we did not see any evidence of this. However, families were welcome to visit the service and both people had a weekly visit from family members or went out with their family.

Requires Improvement

Is the service responsive?

Our findings

The complaints policy was not up to date and there was not an easy read complaints form for people to use if they wanted to make a complaint or a service user handbook to explain the process in an accessible format for people using the service. When we asked care workers how they would respond to a complaint they said, "I definitely have to phone the manager but if it is a correction I can do then and there, I sort it out" and "If I heard a complaint, I would speak to the manager." Neither care worker was aware if the service had complaint forms.

A relative told us, they had raised a concern with the registered manager which resulted in a meeting the next day and a follow up meeting. The relative described it as a "very open and honest meeting". However another relative was unaware of the complaints procedure and felt their complaint had not been fully resolved.

The provider had a standard complaints book but no complaints had been formally recorded. The registered manager had weekly contact with the people using the service and was managing any complaints informally. As there was not a log of complaints and concerns, there was no evidence to show that complaints and concerns raised by people and relatives had been responded to and action had been taken to improve the service as a result of these. We discussed with the registered manager the need to record complaints and complete an analysis to learn from and improve service delivery, which they agreed to implement along with an updated complaints policy and procedure.

This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received personalised care that was responsive to their needs. One relative said, "The staff are very, very caring. [Person] has never looked better or more cared for." Both people had the one to one support they required and one care worker explained one person's specific needs so the inspector was able to conduct the inspection without causing unnecessary disruption to the person.

The registered manager told us they were in the process of updating peoples' support plans and we saw this had been completed for one person's support plan but not the other person's. The support plans and 'About Me' records included essential information such as people's preferred name, likes and dislikes, if they wished male or female support, activities, communication and what support the person required throughout the day both at home and in the community. However for both people we saw that their cultural background and religion was left blank. Care workers said they knew about people's backgrounds from talking with them and their families.

The files were written in a person centred manner with clear guidelines and easy read pictures. For example, 'Staff should encourage me to make decisions for myself regarding my daily activities and give me time to process the choices. Use short simple instructions. Use positive, calming and reassuring language. Ensure I fully understand the language and express verbally what has been said.' Support plans also had a number of

headings with information for care workers about what the person could do and guidelines for how to provide support. For example, 'I can make my own choice when asked if I prefer a bath or shower.'

The support plans did not however record any information around people's wishes, views and thoughts about end of life care and had not been considered as part of the care planning process. We discussed this with the registered manager who said they would incorporate this into the support plans.

There was evidence that people's families visited the service weekly and had ongoing communication with staff, however there was a lack of written evidence to record that support plans were developed and reviewed with people and their families. The support plans were current but we could not see how reviews had been carried out and support plans were not signed or dated to indicate who had agreed to them or been involved in their creation. One relative told us they had not seen their relative's support plan and another said the registered manager had updated the care plan since the inspection and had met with the family to discuss it. It was now with the extended family for comments and signatures.

Regarding activities, a relative said that activities had "started off excellently" when the person was initially placed, "but because of issues to do with staffing, the activities tailed off, but they now have a member of staff who does activities two days per week." A healthcare professional said both people needed "a high level of structure and activity planners with symbols or pictures." We saw people had activity planners which were very flexible and generally dependant on people wanting to do the activity at the time, and the availability of staff as people required two to one support in the community. The staffing issue was being addressed as a care worker had been employed as a second care worker to engage in community activities with people twice a week. The registered manager was also available to provide support as the second care worker if required. Activities people liked to engage in included, arts and crafts, music, dancing, watching TV soaps, bowling, eating out, going out for walks and karaoke. Both people were also supported to go out with their families every weekend.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have up to date policies and procedures to support staff in their roles. For example they did not have a safeguarding procedure that provided guidelines to staff on what to look for in terms of recognising abuse and how to respond and report it. The registered manager confirmed they were aware of this and had employed an external agency to bring the policies and procedures up to date with current guidance and legislation.

The provider had some systems for assessing the quality of the service and identifying risks. However, checks and audits had not always been operated or recorded effectively, or at all. Safeguarding alerts, incidents and accidents and complaints were not recorded centrally and analysed to contribute to improving service delivery. Finance and medicines both had audits but these were not being completed and the medicines audit did not include a stock take. There was no record of care workers having completed competency assessments. Furthermore there were no contingency plan, no recorded fire safety checks, the gas safety certificate we saw was out of date and people using the service did not have personal emergency evacuation plans (PEEPs). This meant the audits carried out to review the quality of the care provided were not always effective in identifying areas to improve or identifying potential risks so these could be addressed and minimise.

The provider had been supporting people since January 2016 but did not have a registered manager until November 2017 and until the time of the inspection had been using agency staff which meant there was a lack of continuity of staff within the service.

Care workers told us they attended team meetings and said, "It's an open discussion about what we think" and "We have team meetings as often as we need them. They're helpful. It's an ongoing thing." However there was no written record of team meetings' discussions and decisions. This meant staff who did not attend the meetings did not receive information and were not kept up to date with what was discussed and any decisions that were made at the meetings. Care workers also told us there were not separate residents' meetings but the people using the service generally joined in with the team meetings.

The above paragraphs were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative of a person using the service told us, "Leadership has been an issue. [The service] has had a bumpy ride in getting a manager and that has had an impact" and "They have made improvements, things are moving in the right direction." A healthcare professional said, "[The registered manager] has made quite a difference. There is a lot more information for service users and visitors" but they noted the policies and procedures were not up to date. They also said, "[The registered manger] is a people's person with genuine caring qualities and that is reflected in the staff."

Care workers felt the registered manager was competent and listened to their concerns. Their comments included, "So far it is good. I haven't had any issues. For listening, [the registered manager] is really good. We

have their private number and at any time we can call her. When she's not in, she calls to ask how everything is", "I am very much supported by [the registered manager]. We work as a team. We have a handover twice a day that is written and verbal", "[Registered manager] responds very much so. It's a little home so we are all hands on" and "Their strong point is they are very concerned about the clients and they try to address issues very promptly."

The provider did have some audits and checks in place including an 'end of day checklist' that provided guidance for care workers to ensure daily records were completed, medicines had been administered, the environment was clean, fridges and cupboards had been checked for perishable foods and fridge and medicine cabinet temperatures were record. The registered manager told us the checklist was the result of a relative raising a concern and the registered manager responding and taking preventative measures. The registered manager also completed a weekly environment checklist that had a comments section but no action plan to indicate how service delivery was improved. They had also begun reviewing support plans so the information was more detailed and person centred.

A relative told us there was good communication with the registered manager and the nominated individual. The registered manager provided the family with a weekly email report of how the week went for their relative. The registered manager and the nominated individual had also agreed to have a formal quarterly meeting with the family until the service became more stable.

The relative said, "The proprietor is very accessible and he's receptive to talking about it. He's trying to do a good job." Another relative said that they felt the nominated individual had not delivered in terms of the service they thought their relative was going to receive when they moved to the home, for example having weekly two to one support in the community.

The registered manager was registered with CQC in November 2017. They were previously a nurse working in learning disabilities services for 30 years. This is the first service they have been registered to manage and as such were familiarising themselves with the current guidance and legislation. They spoke with the nominated individual daily, were networking with another registered manager to share best practice and had cooperated with the local authorities regarding safeguarding alerts. They had made a number of improvements since coming to the service, for example purchasing updated policies and procedures, implementing inductions, advertising for permanent staff and starting to review people's support plans. However they acknowledged there were still improvements to be made which they were focussed on fulfilling.

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 11 HSCA RA Regulations 2014 Need for consent The registered person did not always seek consent for care and treatment from the relevant person and did not demonstrate they always acted in accordance with the Mental Capacity Act 2005 where a service user did not have the mental capacity to make an informed decision. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users or did all that was reasonably practicable to mitigate the risks. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not operate systems and processes effectively to prevent the abuse of service users and to investigate any allegation of abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system for handling and responding to complaints. Regulation 16 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)(2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet service users' care and treatment needs. Regulation 18 (1)