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The Old Rectory

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 January and 1 February 2018 and was unannounced.

The Old Rectory is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Old Rectory provides care and support for up to 40 people who have physical disabilities and learning disabilities. People's needs varied and some people needed support with communication and their healthcare needs. Some people were living with autism and some people needed support with behaviours that challenged. On the day of our inspection there were 33 people living at the service.

The provider was in charge of the day to day running of the care home. A registered provider is a '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.

At our last inspection in January 2017, the service was rated 'Requires Improvement'. We asked the provider to take action and they sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches we found. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. Some improvements had been made, however we found some continued and some new breaches of the regulations. This is therefore the second consecutive time the service has been rated Requires Improvement.

At our last inspection we found that the care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should live as ordinary a life as any citizen. Although the numbers of people had reduced since our last inspection, the service continued to be outdated and not based on current best practice including Registering the Right Support. The provider was in the process of converting the service into smaller, self-contained units that they were planning to use for supported living. This continued from the last inspection and no one had yet moved into the smaller units/flats yet. .

At our last inspection we found that staff were attentive to people, but due to the large number of people present and their varying needs they did not always receive person centred care. At this inspection, we found that this was still the case. There were enough staff to keep people safe but people living at the service had a wide range of needs. Some people were able to talk and make their needs known. However, there was a lack of accessible communication and tools in place to assist people with more profound needs to make their needs known. Similarly, people who were physically able were involved in the running of the service and completed household tasks. But, there was no systematic plan in place to increase people's independence, so opportunities for those with more profound needs were limited.

Staff had spoken with people about their 'hopes and wishes' for the future. However, when people had complex needs staff had recorded they 'did not understand' as opposed to seeking advice and guidance from those that were important to them. As such goals for people to work towards had not been formally identified

The provider and deputy manager told us they had learnt about 'person centred care' when researching supported living. However, they had not formally cascaded this information to their staff team. As such, people's needs had not always been assessed in line with best practice when supporting people with learning disabilities. Staff had not received accredited training in positive behaviour support or de-escalation techniques, even though some people displayed behaviour that could be challenging. Other training, in topics specific to people's needs, such as autism had also not been provided.

Risks relating to people's care and support had not always been assessed and mitigated. The provider had invited a visitor to stay at the service, but had not done any assessment regarding the risks this may pose to people. People had not been asked if they wanted this person to stay. Visitors to the service bought food that one person was unable to eat, and had not been informed their eating and drinking guidelines had been changed by a health professional. We found the person eating food unsupervised that could have caused them to choke, and which was not in line with their updated guidance.

Some people at the service were assessed as requiring continual supervision. The provider had not completed formal capacity assessments on anyone living at the service. However, they told us that these people would be unable to consent to requiring this supervision. They had not applied for Deprivation of Liberty Safeguards, to ensure this restriction was appropriately authorised and lawful. As such, people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice.

The provider and deputy manager completed a range of checks and audits on the service, but had not identified the issues we highlighted at this inspection. Although accidents and incidents were recorded they were not collated and analysed, and as such the provider was unable to identify if there were any patterns or trends which could be acted on to reduce the chances of incidents happening again. Similarly, complaints were documented and responded to, but there was no central log held to review any themes or trends. The provider had not completed right to work checks on staff that begun working at the service. The provider had failed to inform us of important events that had happened in the service.

Some areas of the service smelt of urine, and there was no soap available in the kitchen for staff and people to wash their hands. We discussed this with the provider and they arranged for this to be rectified during the inspection. We made a recommendation regarding ensuring the service was clean and the risk of infection minimised. There was a plan in place to completely renovate the service in a phased way,

People received support to manage their health care needs, and saw a doctor when they became unwell. Medicines were managed safely. The service was not currently supporting anyone at the end of their life. Staff had discussed with some people what they wanted to happen at the end of their lives, but this had not been formally recorded for everyone living at the service. The provider agreed this was an area for improvement.

People and their relatives told us the provider was a visible presence within the service, and they would go to them if they had any concerns. The rating from our previous inspection was displayed clearly and legibly in a frame, as you entered the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks had not always been assessed and shared, which had left people at risk of harm.

Accidents and incidents were not collated and analysed meaning the provider was unable to look for patterns or trends to reduce the risk of them occurring again.

The provider had not carried out right to work checks on staff.

Some areas of the service required cleaning.

Staff knew how to recognise and respond to abuse. There were enough staff to keep people safe.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was aware of the principles of person-centred care; however, people's needs had not always been assessed in line with best practice when supporting people with learning disabilities.

Staff had not received training in topics specific to people's needs.

Some people were under continual supervision, and unable to consent to this and these restrictions had not been appropriately authorised.

Areas of the service were tired, and required updating. However, there was a plan in place to modernise the entire service.

People had enough to eat and drink.

People received the support they needed to manage their healthcare needs. Staff had made referrals to healthcare

professionals when people's needs had changed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people were able to talk and make their needs known. However, there was a lack of accessible communication and tools in place to assist people with more profound needs to make their needs known.

Staff treated people with respect, but there was no systematic plan in place to increase people's independence.

Staff knew people well and had built up strong relationships with them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were attentive to people, but due to the large number of people present and their varying range of needs they did not always receive person-centred care.

Complaints were documented and responded to in line with the provider's policy. However, there was no central log to enable to provider to review concerns and look for patterns and trends.

The service was not currently supporting anyone at the end of their life.

Is the service well-led?

Inadequate

The provider and deputy manager completed a range of checks and audits but had not identified the issues we highlighted at this inspection.

The provider had not notified us of important events that had happened in the service.

Staff cared for people; however, the culture was not person-centred.

The provider had sought advice from a range of professionals.

People and their relatives told us the provider was a visible presence within the service, and they would go to them if they had any concerns.

The Old Rectory

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 was planned to check 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 inspection took place on 31 January and 1 February and was unannounced. Three inspectors carried out the inspection. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We contacted the local safeguarding and commissioning teams for feedback before the inspection.

We spoke with the provider, the deputy manager, four members of care staff and the cook. We looked at eight people's support plans and the associated risk assessments and guidance. We looked at a range of other records including five staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

During our inspection we spent time with the people using the service. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we shared some of our concerns with the local authority safeguarding and commissioning teams.

Requires Improvement

Is the service safe?

Our findings

People told us and indicated, using a thumbs-up sign that they felt safe living at The Old Rectory. We saw feedback from one relative which stated, 'It is very reassuring to know that [my relative] is in such safe hands.' Another relative told us, "[My loved one] is safe here. They are well looked after and have everything they need." Although people told us they felt safe we found concerns regarding risk management, which left people at risk of harm.

At our previous inspection, guidance for staff regarding the risks relating to catheter care had not been adequately assessed and mitigated. At this inspection there was no one living at the service who had a catheter fitted. However, we found that other risks relating to people's care and support had not always been assessed fully or mitigated.

One person had been assessed by a speech and language therapist as requiring a 'soft mashed diet' and supervision when they ate and drank. Although their care plan had been updated to include this up to date guidance we found them in their room on the first day of the inspection eating a bag of sweets. There was a wrapper of an eaten chocolate bar on the bed beside them and no staff were present. We asked the provider to come and observe the person, and they told us, "[Person] really likes sweets." We discussed this incident with the deputy manager and other senior members of staff. Staff were aware of the updated guidance and had not provided the person with sweets. Staff told us they must have been given to the person by visitors, who had been present at the service earlier in the day. Visitors to the person had not been informed of their changing needs and their new eating and drinking guidelines. There were no records kept of when staff checked on people in their rooms, so we were unable to tell how long the person had been in their room, eating the sweets unobserved, leaving them at risk of choking. The deputy manager told us they thought it could have been, 'about an hour.'

During the inspection the deputy manager placed a sign in the person's room stating their eating and drinking guidelines had changed, telling visitors they should consult with staff. They also wrote a letter to the person's regular visitors informing them of the changes.

On the second day of the inspection staff left the person drinking a drink unobserved during lunch time when they went to collect their pudding. We reminded staff of the person's eating and drinking guidelines and the need for observation. We asked the provider to discuss these incidents with the local authority safeguarding team, which they did, during the inspection.

The provider had invited someone to stay at the service for an indefinite period of time. They were not in receipt of any care, and were a relative of someone who had lived at the service nine years previously. The provider had kept in touch with the visitor via email but had not met them in the nine years since their loved one had lived at the service. No consideration had been given to the risks of an individual the provider had not met for nine years staying at the service. People had not been consulted if they wanted the individual staying in their home. We discussed the potential risks with the provider and they told us, "I had not considered that." They asked the visitor to stay somewhere else whilst people were consulted and the risks

assessed and appropriate checks carried out.

At the previous inspection accidents and incidents were not collated or analysed to identify why they had occurred and if anything could be done to prevent them happening again. At this inspection, accidents and incidents were not consistently recorded and were not always completed by the staff involved. There was a risk information relating to the incidents may not have been fully accurate. Individual incidents were reviewed by the deputy manager, and people's care plans were updated if there were any changes needed to their care and support. However, there was still no overview to check for any patterns and identify themes.

The provider had failed to ensure that care was provided in a safe way to service users. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not always been recruited safely. Three staff did not have interview notes on their file, and although the provider and deputy manager told us they had completed formal interviews to ensure staff were competent and suitable for the role, they were unable to locate them. Right to work checks had not been completed by the provider, to ensure staff had the right to work in the UK. The provider had applied for all staff to have a check from the disclosure and barring service (DBS) to ensure they were safe to work with vulnerable people. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care services. One staff member was working at the service, under supervision, whilst they were waiting for their DBS to return.

The provider had failed to ensure that staff were recruited safely. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection staff had not been deployed effectively. We observed periods of time when there were no staff present, and people needed support. At this inspection staff were available to offer support to people. People and their relatives told us there were always staff there if they wanted to talk with them or if they needed anything. One relative commented, "I will always speak to [the provider] or any of the staff with any concerns. There is always someone around."

The deputy manager did not use a dependency tool to establish the number of staff needed and was in the process of obtaining advice regarding this. They monitored the staffing levels to make sure there were enough staff to support people with appointments and outings. The duty rotas showed there were consistent numbers of staff on duty. Staff worked flexibly to cover any emergency shortfalls, such as sickness. During the inspection staff were not rushed. Some people were funded to be supported by staff on a one to one basis. The deputy manager monitored these hours to check people were receiving the right level of support.

The service was not consistently clean. The kitchen floor was not clean by the base of the cooker and dish washer. There was no soap in the kitchen for staff or people to wash their hands. We raised this with the provider during the inspection and they arranged for this to be remedied. One person's bedroom, one unused bedroom and a communal lounge area had a very strong odour of urine. We discussed this with the provider. They immediately arranged for a contractor to deep clean these areas.

We recommend that the provider seeks advice from a reputable source regarding ensuring the service is clean and the risk of infection prevented.

There was a cleaning schedule in place and people's rooms and bathrooms were clean. Staff had completed

training about infection control and food hygiene. They wore personal protective equipment, such as gloves and aprons when needed.

Regular health and safety checks of the environment and equipment were completed to make sure it was safe. For example, water temperatures were checked to make sure people were not at risk of scalding. Windows were fitted with restrictors to make sure people were not at risk of falling through them. Gas and electrical appliances were checked to make sure they were kept in good working order.

Staff had completed training about fire awareness. Fire resistant doors were kept closed and fire exits were clearly marked and kept free of obstacles to make sure people would be able to get out quickly in an emergency. Emergency lighting and fire alarms were tested. Staff completed regular fire drills and knew how to respond in an emergency. People told us they had been involved in fire drills. Each person had a personal emergency evacuation plan (PEEP). A PEEP sets out the specific physical and communication needs of each person to ensure they could be safely evacuated in an emergency. The provider had a business continuity plan which set out actions to be taken in the case of an emergency, such as a fire, gas leak or flood. This included having three alternative places for people to stay if needed.

Staff knew how to recognise and respond to abuse. One member of staff told us, "We would look for agitation, changing behaviour and marks or bruising." The provider and deputy manager had reported any safeguarding concerns to the local authority. They were due to meet with the local safeguarding team after our inspection to discuss the service and recent concerns that had been raised.

The provider had assigned the oversight of medicines to a senior member of staff and they had ensured there were appropriate arrangements in place for obtaining, recording, administering and disposing of prescribed medicines. Medication Administration Records (MARs) were fully completed, showing people received their medicines as and when they needed it. The dose of some people's medicines, such as warfarin, to thin people's blood, changed regularly. Staff monitored this closely to ensure people received the correct amount each time. When people went out with their friends or family staff made sure they had any medicines they needed with them and checked they had the correct amount with them when they returned to the service.

Some people had medicines on an as and when basis (PRN). There was clear guidance in place so staff knew when people might need these medicines and how much they should take. Staff completed body maps to show where and when they applied people's creams. Staff recorded when they had opened bottles of medicines and creams, so they were able to ensure they were still working effectively. Medicines were stored at a safe temperature.

Requires Improvement

Is the service effective?

Our findings

No one new had moved into the service since our last inspection. People's needs were regularly reviewed and when any changes to their care and support were necessary their care plans were updated accordingly. However, due to the service's large size and varying needs of people, these assessments and updates were not always completed in line with current best practice when supporting people with learning disabilities. Staff had not received training in topics specific to people with learning disabilities, such as person centred active support (a way of supporting people to be as independent as possible) or person centred planning (a way of helping people to plan their life.) The provider and deputy manager told us they had learnt about person-centred care whilst researching supported living services, however, they had not formally shared this knowledge with the staff team.

When people displayed behaviour that challenged staff did not always have the skills and knowledge to implement agreed best practice such as NICE guidance regarding challenging behaviour and learning disabilities. Staff told us of incidents when people had become distressed and physically aggressive. One person's care plan directed staff to physically intervene if they became 'frustrated and aggressive.' Although staff had received training in 'challenging behaviour' they had not received accredited training in de-escalation techniques or had their competency assessed to ensure they were safe to physically intervene. We discussed this with the provider and they agreed that staff would benefit from an accredited course in positive behaviour support.

Other training courses, such as moving and handling had been completed online, but there had again been no practical assessment of staff competency. We observed staff assisting people to move safely. However, without a formal assessment of their competency there was a risk that people could be supported in an unsafe manner.

The provider had failed to ensure that staff were fully trained to be able to complete their roles effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had regular one to one supervision with the deputy manager to review their performance. New starters completed the provider induction programme which included completing the care certificate and shadowing more experienced staff members whilst getting to know people gradually. The care certificate is an identified set of standards that social care workers work through based on their competency. Staff told us that the best way to get to know people was to make time to speak with them.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The deputy manager had completed a 'decisions booklet' for each person. This outlined different decisions ranging from being able to 'choose my own clothes' and 'administer my medicine.' Staff showed an awareness of The MCA and told us how they offered people choices and one member of staff said, "We ask people what they want to wear, what they want to eat, what they want to do that day." Although these booklets were in place, and were useful to staff no formal assessment of people's capacity had been considered.

The deputy manager and the provider had not applied for DoLS for anyone living at the service. Some people living at the service had been assessed as requiring constant supervision, to protect themselves and others. These people had complex needs, and although the provider had not completed a formal capacity assessment on them, the provider and deputy manager both told us they believed these people lacked the capacity to consent to these restrictions.

The provider had failed to ensure that restrictions on people's liberty was appropriately authorised. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection staff had not taken action when one person had lost weight. At this inspection people's weights were monitored closely, and when people were documented as losing weight staff had taken action and referred them to healthcare professionals. Some people's food was fortified with high fat foods such as cream and cheese to help their weight to remain stable. Most people sat and ate together in the dining room. Some people chose to eat in their bedrooms and their choice was respected. People told us they enjoyed their meals and that the food was good.

Staff supported people with their healthcare needs. People had separate health action plans to take with them to hospital if they became unwell, containing important information about their healthcare needs.

Some people were unable to tell staff when they became unwell. Staff told us they had noticed a change in a person's behaviour and they had supported the person to see a doctor. The person was diagnosed with a skin condition and they had now been prescribed medicine to help their skin improve. Staff were knowledgeable about the person's skin condition and told us of potential triggers for it to deteriorate, including if the central heating was on in the service.

One person had been supported to have a smear test. They gave the person the option of going into the appointment independently or with support from staff. The person chose to have staff support them, and with reassurance was able to receive this important medical check.

Some areas of the service were in need of decorating and had peeling wallpaper and heavily chipped paintwork. The provider was in the process of converting the service into smaller, self-contained units, and there was a plan in place to redecorate the whole of the service as part of this work. This was being doing in a phased way, to ease disruption for people.

People proudly showed us their rooms and these were personalised with photographs, pictures and their own ornaments. People had chosen how they wanted their rooms decorated. People's bedding appeared clean and people told us they had chosen their own duvet covers. For example, some people had bedding displaying their favourite football team. Some bathrooms had recently been decorated and had sufficient

room to allow the use of specialist equipment such as hoists.

Requires Improvement

Is the service caring?

Our findings

Staff treated people with kindness and relatives told us they felt staff cared for their loved ones. We saw feedback from relatives which stated, 'It feels like a home. Warm secure and friendly, and the staff care about the residents as people.' Another relative had said, '[My loved one] has been with you for some considerable time now and the first thing that comes to mind is that you've never given up on them…not only have your staff handled them safely and with kindness, they have always been very sensitive and supportive to [name] and I.'

Although feedback from relatives and people was positive, people were not always encouraged to be as independent as possible and staff did not always seek accessible ways to communicate with them. People living at the service had a wide variety of needs. Some people were extremely able and could come and go as they pleased. They spoke with staff and made their needs known easily. However, some people had more profound needs and required support to communicate verbally. There were no systems in place to support these people to make their needs known. Since our last inspection the provider had introduced a white board, with small pictures on, showing what was for each meal. There were no other forms of accessible communication, such as pictures to show which staff were on duty or what activities were on offer each day. People's care plans were not written in an accessible way.

Staff ensured people had the drinks and food they needed, however their opportunity to participate in their preparation was limited. Staff bought round on trays pre-prepared tea and coffee for people, with milk already added. People were given the choice between the two but were not given the opportunity to make their drinks themselves, choose how strong they wanted them to be, or choose to have them without milk.

We spoke with staff about people's involvement in the running of the service and staff gave us individual examples, including one person who helped to peel potatoes for meals and one person who enjoyed putting their laundry away. People who were able took their plates and cups and returned them to the kitchen after meal times. Although these individual examples showed that some people were able to carry out household tasks, there was no systematic plan in place to increase people's independence or support those with more profound needs to participate in the running of the service. People with more profound needs had things done for them, and although staff treated them with kindness, opportunities to increase their independence was limited.

People were not always treated with respect, and at times staff, rather than people, were in control of the service. On the first day of the inspection, people ate their lunch and remained sat at the tables. A member of staff walked in to the dining room and said, "Ok troops, have you finished? You can go." People then left their tables. Another member of staff said, "Push the chairs in when you leave the table so I can wipe them." People looked to staff for advice and guidance, and although this was provided, they did not always have an ownership of the service.

The provider had failed to ensure that people received person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people had lived at the service for many years and staff were aware of people's established routines. Staff told us they provided individualised care to people, for example knowing that one person likes their bed made as soon as they get up, and that they become distressed if their shoes are not lined up, and they prefer the lamps and lights to be on in their room. Staff told us by knowing the persons preferences they were able to reduce their anxieties.

Everyone we spoke with told us they were happy living at The Old Rectory. One person said, "I have known [five people] since we were at school. We are friends." A relative said, "[My loved one] gets good care. They [staff] will always call me if there is anything wrong." People appeared relaxed in the company of each other and staff.

People were supported to maintain their relationships with their friends and loved ones. Staff asked people if they would like to call their relatives and supported people to make these phone calls. We saw feedback from relatives which stated, 'I have always been made to feel welcome." "Staff are happy to chat to me for as long as necessary.' 'The families are invited to join in at events at The Old Rectory and are kept 'in the loop' with regular newsletters.'

Staff treated people with kindness and we observed them spending time with people, smiling and joking. Staff told us people were "Treated with dignity at all times." Staff told us they ask people discretely if they need support and always ensured they shut doors when providing personal care.

When people needed additional support to make decisions about their care and support an advocate was arranged. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Whilst people ate we observed kind interactions, where staff took time to speak with people, bending down to their level. Staff told us "We are friendly. We cater well to people's needs" and, "We really care about the guys."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we discussed with the provider the difficulties a large service for people with learning disabilities had, when seeking to provide person-centred care. Staff were attentive to people, but due to the large number of people present and their varying range of needs they did not always receive person-centred care. Some people were able to come and go as they pleased and assisted with the upkeep of the service. Other people required more support to be independent. People knew where to find staff if they wanted something but it was more difficult for people who were unable to verbally communicate, or people who were less outgoing, to gain the staff's attention outside of the routine times. People did not have formal goals in place so were not working towards becoming more independent and people with more profound communication needs needed additional support to make their needs known. We made a recommendation regarding this.

At this inspection the provider was in the process of converting the service into smaller, self-contained units and was planning for people to move in, in a phased way and have more control over their service and environment. They agreed that the current size and spread of people's needs made it difficult for people to receive person-centred care.

Staff had discussed people's 'hopes and wishes' with them. However, when people had profound needs they had recorded that they 'did not understand' and had not considered any goals or aspirations people may have. They had not consulted with their loved ones to see if they had any ideas about what people may want to achieve. Staff had recorded that one person wanted to go to Disneyland 'when they were better.' No consideration had been made as to how to support the person to go to Disneyland whilst receiving support from staff.

The deputy manager showed us new review paperwork that they had created. This contained information regarding what people could do for themselves, such as cooking and cleaning, and how they could be supported to learn new skills. They said they planned to introduce this for people living in supported living.

The provider had failed to ensure that people received person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place and the deputy manager told us there had been no complaints in the past year. We were aware of concerns that had been raised by healthcare professionals, and we had also contacted the service since our last inspection regarding low level concerns that we had received. Although these had been responded to, the information regarding these concerns had not been recorded centrally. This meant complaints and concerns were not collated and analysed to look for any trends or patterns and possible ways of reducing the chance of concerns arising again. We discussed this lack of central review and the deputy manager showed us a matrix they had developed to review future complaints. People told us they did not have any complaints. They said they would speak to the provider and the staff if they had anything they were worried about and felt confident they would help.

We recommend that the provider seeks advice from a reputable source regarding the management of complaints.

The service was not currently supporting anyone at the end of their life, although had done so in the past. Staff had discussed with some people what they wanted to happen at the end of their life. These discussions had been documented and some people had funeral plans in place, outlining the music they would want and any flowers, for example. These had not been introduced for everyone at the service. We discussed this with the provider, and they agreed this was an area for improvement.

We recommend that the provider seeks advice from a reputable source regarding the implementation of end of life care plans.

During the inspection people kept busy. Some people helped with cleaning and taking cups to the dining room. People enjoyed a music session and were singing along, clapping, smiling and laughing. Some people preferred to spend time in their own rooms listening to music, watching the television or doing jigsaw puzzles. Staff respected people's choice about where they wanted to spend their time and what they wanted to do. On the evening of the inspection some people were involved in the local Olympic special needs team and proudly showed us their tracksuits. They were visibly excited to be going to their weekly meeting.

Inadequate

Is the service well-led?

Our findings

The provider was a visible presence at the service, and people approached them throughout the inspection. Everyone we spoke to told us they knew who the provider was and that they would go to them if they had any concerns. Staff told us, [The provider] and [deputy manager] are always approachable" and, "[The provider] treats everyone like family." We saw feedback from relatives which stated, 'Staff are very helpful' and 'Staff work hard doing the best they can. They are always helpful sorting any problems out.'

However, despite these positive comments we found that this service was not always well led. There were continued breaches of regulations and new breaches of regulations. The provider's governance systems had not picked up the issues we found at the inspection and had not identified continued and new breaches of fundamental standards and regulations. The culture had not changed and there continued to be a lack of person centred care for each person. Some improvements had been made, including to medicines management, but improvement was not widespread with a history at this service of non-compliance with regulations.
Risks to people continued, including the risk of choking to one person not being mitigated. The provider had allowed an acquaintance he had not seen for nine years to live at the service without assessing potential risks or consulting with people about this arrangement.

At our previous inspection we identified concerns relating to safe care and treatment, good governance, person-centred care and staffing. The provider sent us an action plan telling us how they would become compliant with the regulations and fundamental standards. At this inspection some improvements had been made, and we found there were no longer concerns regarding staff deployment at the service. Other concerns relating to the guidance available for staff had also been rectified and the registered manager now regularly reviewed and updated people's care plans when people's needs had changed. Although we found some improvements, we did identify one instance when staff had not fully documented advice from a healthcare professional. The district nursing team did not leave written guidance for staff, so staff had been verbally handing over their advice. Staff told us conflicting information regarding the support a person had received when they had red marks and scratches on their skin. The provider contacted the district nursing team, and they confirmed the person had received the support they needed, and their skin was now healing.

We found multiple instances where staff had written that people had been 'aggressive' in their daily notes, but there was no description of their behaviours or what they had been doing. Incident forms were usually completed by the deputy manager based on verbal feedback from staff or information in people's daily notes, but as such did not contain the level of detail necessary to ensure a true analysis could be completed regarding what had happened and why. Accidents, incidents and complaints were not collated and analysed to look for trends and patterns to look to reduce the risk of them happening again.

The provider and deputy manager completed a range of checks and audits on the service, including on medicines and people's daily notes; however, they had not identified the concerns we highlighted during our inspection. The deputy manager worked with staff to observe their practice but they did not record these observations. The provider and deputy manager were receptive to our feedback and promptly dealt

with issues when we raised them. On the second day of the inspection they had drawn up an action plan to rectify the issues we had identified.

The provider had failed to maintain accurate and complete records. The provider had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services that provide health and social care to people are required to inform CQC of events that happen, such as a serious accident, so CQC can check that appropriate action was taken to prevent people from harm. Staff told us about an incident that had occurred in December when the police had been called. The provider had failed to notify us of this incident, as required by law.

The provider and registered manager had failed to notify CQC of notifiable events in a timely manner. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider sought views from relatives, people and staff. Relatives were always welcome at the service and regularly visited their loved ones. They were regularly invited to events organised by the provider at the service. One relative told us, "The families are invited to join in at events at The Old Rectory and are kept 'in the loop' with regular newsletters." We saw positive feedback from relatives, such as, 'They [my loved one] always tell me that they are happy living at The Old Rectory."

People had been supported to complete easy to understand questionnaires but these responses had not yet been collated and analysed as they had only recently been completed. Staff views were gained at regular team meetings, and staff told us the provider was accessible and always willing to take their feedback on board.

Following our previous inspections the provider had sought advice from a range of professionals. They had actively engaged with the local care home nurse advisor to make improvements to their medicines processes. Staff spoke with pride about the changes they had made to ensure people received their medicines safely, and were proud that a recent audit by a local pharmacist had showed no concerns.
The local authority commissioning team had also been involved in supporting the provider to change the service. The provider told us this support had recently reduced. They were due to meet with the local authority commissioning and safeguarding teams to discuss how to move forward.
At our last inspection we identified that many people had lived at the service for a number of years and appeared relaxed and happy in their environment. The provider, staff and relatives all described the service as having a 'family feel.' People's needs were met and improvements were being made; however, due to the size, layout, culture and varying needs of people it was sometimes difficult for staff to provide person-centred care. Staff knew people well; however there was a lack of visual aids to ensure that people who needed support with their communication were able to make their needs known. At this inspection we found the same situation.

The provider agreed that the current service model was outdated, and was aware of recent best practice guidance, such as Registering the Right Support. As such they were in the process of converting the service into self-contained units, and were planning on changing the service into supported living but no one had moved into a smaller unit or flat since the last inspection. They agreed that it was difficult to provide person-centred care using the current service model. The provider had involved people and their relatives in these plans, and people spoke to us excitedly about the prospect of living in 'a flat' with 'their friends.'

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about a service can be informed of our judgements. The provider had displayed the rating conspicuously in the 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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that care was provided in a safe way to people.

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 had failed to ensure that restrictions on people's liberty was appropriately authorised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain accurate and complete records. The provider had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people.

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 had failed to ensure that staff were recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were fully trained to be able to complete their roles effectively.