Westwood Homecare (North West) Limited

Sedgeborough House

Inspection report

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27 July 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 26 and 27 July 2017 and was announced. This meant we gave the provider 48 hours' notice of our intended inspection to ensure that the registered manager or a representative would be available in the office to meet us.

Sedgeborough House is a domiciliary care service providing personal care and support to people living in their own homes including, older people, people living with dementia, and people with physical disabilities. The support hours varied from one half an hour call a day to four calls a day, with some people requiring two members of staff at each call. At the time of the inspection the service was supporting 12 people within the local community.

At the last inspection in March 2016 we identified three breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to systems not being in place to fully assess and monitor the quality of the service and staff had not received appropriate necessary training and professional development to enable them to carry out their role effectively. Mental capacity assessments had not been undertaken and the service was not operating in accordance with the Mental Capacity Act 2005.

At this inspection we identified on-going breaches of the regulations in relation to need for consent, staffing and good governance. We found a further four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care, safe care and treatment, and fit and proper persons employed.

There was a registered manager in post, who was also the nominated individual. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to the inspection we were informed the registered manager was due to retire and the provider was actively looking to recruit a new manager. At the time of our inspection the registered manager had been asked by the director to assist with the inspection process, which she did. We were informed by the registered manager she had officially left Sedgeborough House on 14 July 2017, but assisted with the inspection process to help the director.

During the inspection the director informed us that she had taken responsibility for managing Sedgeborough House for the last two months, working alongside the registered manager until she left on 14 July 2017. However, during the inspection we noted the director did not have experience working in adult social care and had not undertaken any key training to ensure she was competent in her role. Shortly after the inspection we were informed by the director the registered manager had returned to her role as

manager, until the provider recruits a new experienced manager.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a lack of scrutiny and oversight by the registered manager to ensure that people received safe care and treatment. The management team did not regularly review people's daily notes so they were unaware of changes to people's support or incidents that occurred and did not follow them up to ensure that appropriate action had been taken.

People's care plans did not contain the detail needed to keep people safe including guidance for staff about how to reduce the risk of pressure sores. One person was at a high risk of developing pressure sores and we found service had not developed a pressure sore risk management plan.
We noted one person needed assistance with eating and drinking. This person had specific dietary needs to help manage their health condition. This was not recorded in their care plan. Care plans also lacked information on how to support people to move safely or remain independent. People's care plans had not been audited by the registered manager.

People's medicines were not always managed safely. We looked at people's care plans and found gaps in information regarding people's medicine that were supported by the provider. We found no specific medication risk assessments in place that would details the person's ability and the support they required.

Staff reported accidents and incidents to the office however; the management team did not review them to ensure appropriate action had been taken and to reduce the risk of incidents happening again.
Recruitment was not carried out in a safe manner. The provider did not request references from the latest employers for one staff member that we looked at and we found no medical health questionnaires on file for two new staff.

The service did not follow the principles of The Mental Capacity Act 2005. Some people's relatives had signed to consent to the care provided by the service, we noted people's mental capacity had not been fully assessed.

Staff were not supported by robust systems of training and monitoring. We found that the provider still didn't have a clear overview of what training staff required. The provider did not follow a clear induction for new staff and the care certificate had not been introduced.

People did tell us that staff were kind and caring, and when they offered support, treated them with respect and dignity.

There was no effective monitoring of the quality or safety of the service in place, and no routine audits were being undertaken at the time of the inspection. This increased the risk that staff would not identify or be able to act on any areas where improvements were required.

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.

Not all risks to people were assessed and guidance was not available to make sure all staff knew what action to take to keep people as safe as possible.

The provider did not have an effective recruitment and selection procedure in place and relevant checks and processes were not carried out on the suitability of staff.

Medication administration records (MARs) were in place. However, we found no medication risk assessments for people.

Is the service effective?

Inadequate

The service was not effective.

The registered manager had not acted to put in place robust programmes of training to ensure that staff had the competency to meet people's needs.

The principles of The Mental Capacity Act 2005 were not always followed. People's relatives had signed to consent to their care when people had the capacity to make decisions for themselves.

There was a lack of guidance for staff to ensure they assisted people to eat and drink safely.

Is the service caring?

Good

The service was caring.

People were treated in a kind, caring and compassionate way.

Staff had developed positive relationships with the people they supported and knew them well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not contain necessary guidance to ensure staff gave the personalised care and support people needed.

Care plans had not been reviewed and updated when people's needs had changed.

People knew how to raise concerns and complaints about the service and a policy was in place to support this.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service.

The provider had not ensured that the requirement notices from the previous inspection had been complied with.

The provider did not get feedback on a regular basis from people using the service, relatives or staff.

Sedgeborough 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 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 26 and 27 July 2017 and was announced. The provider was given 48 hours' notice of our intended visit to ensure the registered manager or their representative would be available in the office to meet us.

The inspection team consisted of one adult social care inspector.

Before our inspection, we reviewed information we held about the service. We looked at statutory notifications sent to us at the Care Quality Commission (CQC). These are notifications providers are required to send to us about safeguarding incidents, serious injuries and other significant events that occur whilst they are providing a service. We contacted Manchester Council Commissioning team for information; we didn't receive a response. We also contacted Manchester Healthwatch who didn't have any intelligence on this service.

We reviewed information sent to us by the provider in the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we visited two people at home with their prior consent and made telephone calls to four people using the service and six relatives who had agreed to speak with us.

We spoke with the registered manager, two directors, one senior care worker and three care workers. We reviewed two people's care records including two records kept in people's home (with their permission) and two staff recruitment records and training files. We looked at a range of other records including the staff induction records, supervision schedules, staff rotas and quality assurance surveys and audits.

Inadequate

Is the service safe?

Our findings

People told us they felt safe when staff were supporting them. One person said, "I feel safe at home, the staff make sure of this." Another person said, "The girls [care workers] are good, they make sure they lock the front door before they leave, I guess this keeps me safe." Although feedback was positive, we identified issues regarding risk management and people were not always supported safely in their homes.

Appropriate arrangements were not always in place to ensure that people received care and support safely. Where risk assessments were in place we found that these solely related to people's home environment and not the support they needed to undertake activities of daily living.

Risks relating to people's health and wellbeing had not been considered. For example, one person had recently been discharged from hospital and required their pressure area care to be monitored or managed to prevent the breakdown of their skin. There was no support plan in place detailing the specific care and support to be provided or if the person was able to self-manage their pressure area care. Risk assessments and support plans were not in place in relation to skin integrity, nutrition, continence care, administration of medicines and pressure ulcer management. We noted this person also required support from the district nursing team to ensure their skin integrity care was managed safely, however we found no evidence of the nursing team involvement. Although we found care staff had been keeping daily records for the monitoring of this person's pressure areas and their fluid intake, we noted there was no specific guidance in place to advise staff what actions they needed to follow, to ensure that this person was supported safely and to maintain their health and wellbeing. We noted both the provider and the discharging hospital had not made an appropriate referral to the community nursing team, to ensure this person received specialised skin integrity care at home. During the inspection CQC raised this matter to the Trafford Safeguarding team. This is currently being investigated further, CQC will continue to monitor this situation.

Furthermore, risk assessments were not always fully completed for people's movement and handling needs. For example, one person required to be supported with their moving and handling transfers using a hoist. We found there were no clear instructions on how the person required assistance to transfer from their bed to their wheelchair. During the inspection we spoke to the staff at this person's home and they advised they weren't sure whether to use the hoist due to the person not being well at the time. This meant staff had no clear instructions on how to safely manage this person's transfers, due to no moving and handling support plan being in place.
The above risks had not been identified or anticipated and people were at risk of receiving care and support that was unsafe and did not meet their needs. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that environmental risk assessments had been identified and completed for people using the service. Examples of environmental risk assessments included various aspects of the home environment, such as the kitchen or the stairway. We noted this documentation at times was generic and many of the answers provided used a tick box method without detailing any areas of concern noted or guidance for staff in how to mitigate the identified risks.

We looked at a sample of two staff records for staff recently recruited. We found one of the applicants recruitment records had been completed correctly, although we noted there was no medical statement on file. In the other staff file we found there was an inconsistent approach to safe recruitment. We found the provider had not requested the applicant's previous employment references; instead there were two character references on file. We queried why the provider had not requested the applicant's previous employment references and we were informed by the director they were not aware character references were not acceptable. The director had not made any inquires at the time to why the applicant had not requested their previous employee reference. In both staff recruitment files we found no evidence of medical statements. Medical statements enables new starters to declare any health condition or disability which may affect their ability to do the job they have been offered, so the provider can ensure the staff member is appropriately supported.

This meant that the provider could not ensure that care workers had the appropriate knowledge and skills to provide safe and suitable care as suitable references had not been obtained.

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

Both files we checked had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups.

We looked at two people's care plans and found gaps in information regarding the support people required with their medication. We found no specific initial medication assessment in place that should detail the person's level of ability, the support they required and whether there are any potential risks the provider needs to consider.

We noted from the providers training records all staff had received medication training. However, it wasn't clear how often staff would receive refresher training as we found one staff last completed medication training in 2010 with another completing this in 2012. Staff competency assessments for administration of medicines were not in place. Therefore, we could not be satisfied staff had the necessary training and support to provide medication administration safely.

When we visited two people in their homes, we reviewed their medication administration records (MARs) with their permission. The MARs we viewed did not record the stock of medicines at people's homes. Therefore, people's boxed medication had not been booked in and there was no on-going count to ensure the medication was accounted for. We noted one person's MAR chart had a number of missing signatures. Although this person had been in hospital, the staff team had not used the MAR allocated key to confirm the person was not available to take their medication. We noted from the provider's quality assurance checks that MARs were collected to take to the office on a month by month basis and the registered manager would audit MAR charts. However, we found no evidence from the medication audits if or that the manager followed up on missing signatures. The medication audit consisted of the manager signing the top of MAR charts to confirm she had viewed them.

We also found that as required (PRN) protocols were not in place within the files reviewed. PRN protocols should provide clear guidance so staff know when people might need these medicines and how much they should take. Topical administration records for creams or ointments applied to the skin, with relevant details such as where to apply the cream, were not in place. Therefore, we could not establish if people had been administered these topical medicines in line with their prescriptions. We found creams or ointments recordings were documented in people's daily communication notes.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to have safe and effective systems in place for the management of people's medicines.

Electronic call monitoring was being used by the service at the time of our inspection. People and staff we spoke with did not indicate there were any timing issues with visits. Visits were predominantly for 30 minutes or up to one hour in duration. Staff we spoke with did not feel rushed or pressurised when undertaking support visits.

If the service identified, or were made aware of, any timing issues with any calls undertaken people told us they were notified of this. We spoke with a person using the service who told us, "The staff can be five minutes later due to traffic, but most of the time its fine."

Policies and procedures were in place in relation to safeguarding adults. A copy of the registered provider's procedure was available for all staff to access within the office. Staff spoken with demonstrated an understanding of what action they needed to take in the event of a person being abused or if they suspected abuse was taking place. Staff explained that they had a responsibility to protect vulnerable people from harm and they described the different types of abuse and the signs that they may need to look for that would indicate abuse may have taken place. They described possible mood changes in a person, for example from being quite chatty to becoming quite withdrawn. From the training records viewed we found staff had completed training in safeguarding vulnerable adults.

The registered provider had a whistleblowing policy in place and staff told us they were aware of this. Whistleblowing can be defined as raising a concern about a wrong doing within an organisation.

All the people using the service received assistance from care workers with their personal care, for example, with washing and dressing and continence. We asked people and their relatives if care workers used personal protective equipment, such as gloves and aprons, when assisting with personal care. All of the people we spoke with said that care workers did use gloves and aprons. Staff we spoke with confirmed they always had access to personal protective equipment and we saw one member of staff put on clean aprons and a new pair of gloves whilst undertaking a visit and before providing care. This demonstrated that staff were aware of infection control and took measures to prevent cross-infections occurring.

Inadequate

Is the service effective?

Our findings

At the last inspection in March 2016 we found breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a number of shortfalls in training for staff. At this inspection we saw some improvements had been made by the provider, however there was still a lack of overview of what training staff required.

We asked the provider and registered manager for the staff training records. They were unable to provide an overview of what training staff had completed, therefore we looked at staff files to evidence training certificates for each member of staff along with a computerised system that had not been fully updated with staff training. There was no training programme or training plan identifying when staff required training or training updates and no staff development plan in place.

The provider adopted an inconsistent approach to the training staff received. We viewed the training records of 15 staff members. We noted staff were provided with three to four key training subjects such as Safeguarding and Protection of Vulnerable Adults (POVA), moving and handling, and medication. We found some of these courses had been completed over a period of five years, and it wasn't clear from the provider how often staff would receive refresher training. The provider explained training is provided by an external company. We noted a small number of staff had completed first aid, food hygiene and one staff member had recently completed a qualification in dementia awareness.

We asked the director how staff were assessed following the training to ensure they are competent, the director could not evidence that staff were assessed following the training to ensure they were competent or to see if the training had been effective. Therefore we could not be assured that staff had been provided with training that equipped them with the skills and knowledge to undertake their role and responsibilities, meet their personal training and development needs and to ensure people's needs were being met safely and to an acceptable standard.

Staff confirmed they had not received specific training relating to skin integrity care despite providing care packages to people with this assessed need and other various health conditions, for example pressure ulcers. Advice on the care of someone with pressure ulcers was passed on by other members of staff who were not trained to deliver this specific training.

The provider had an induction policy and procedure in place, however we found this had not been followed correctly. Some staff we spoke with told us that they did not believe they had completed the induction process fully. We noted that the registered provider did not have systems in place for new staff to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. The minimum standards that should be covered as part of induction training of new care workers.

The failure to ensure that staff received an appropriate induction and relevant training and was competent to undertake their roles was a continued breach of regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Supervision sessions were undertaken by the registered manager every three months and staff confirmed that these were happening. However, we found these supervisions did not include an annual appraisal. Staff we spoke with found these meetings with the manager useful and they told us they could raise any concerns they had.

At the last inspection in March 2016 we found a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not operating in accordance with the Mental Capacity Act 2005. We found the provider was still not compliant and we found no improvements in this area.

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. We checked whether the service was working within the principles of the MCA.

The provider did not have a system in place to assess the capacity of the person to make decisions in relation to specific aspects of their care. Capacity assessments for people living with dementia were still not being completed. For example, we noted from one person's care plan they were living with dementia and required support with their medication by staff. We asked to view this person's mental capacity assessment to see why they needed support with their medication; however the provider had not undertaken this assessment and thought this would be done by the local authority. We found no evidence of any mental capacity assessment being completed by the local authority.

One of the care plans we looked at contained the signature of a family member however, it was not clear if the person using the service had capacity or not. In other care plans, members of the family had been involved in making decisions regarding the care for the individual and had signed their consent, but there was no evidence on file to suggest that people using the service lacked mental capacity. Family members must have 'lasting power of attorney' for health and welfare decisions before they can consent on behalf of the person. In the absence of an LPA, there must be a best interest's decision. The MCA Code of Practice gives advice about how to reach such a decision. The care records we viewed contained no evidence to show this authority was in place, nor that any assessments of mental capacity had taken place. This information is essential to ensure that decisions made on behalf of people are lawful. The service was not assessing and documenting, where necessary, people's ability to consent to care.

The service was not acting in accordance with the Mental Capacity Act 2005 and was therefore a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were aware of the people who required nutritional support and people's known food preferences by speaking to people and their close family members. However, there was a lack of guidance for staff to ensure they supported people fully when they were eating and drinking and to ensure that's peoples individual nutritional needs were met. During a home visit we noted one person was being cared for in bed. We were informed by the care staff that this person now required a soft diet due to their reluctance to

eat solid food but the reason for this had not been explored. We also noted this person was prescribed and being supported with supplementary drinks; however this had not been recorded in the person's care plan. The care plan did not detail what assistance this person needed with their meals, the consistency of their food or how often supplementary drinks should be offered. We found no evidence from this person's care plan of any involvement or referral to the speech and language team or dentist to ensure this person had been appropriately assessed to make sure there eating and drinking needs had been considered.

The provider did not have sufficient guidance for staff to follow to show how risks relating to people's health and nutrition were mitigated. This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were supported to maintain good health and had access to other healthcare services as required. For example, one family member told us their relatives visited the optician and dentist. However, we found care plans did not accurately record the health professionals that were involved in people's care.

Good

Is the service caring?

Our findings

We asked people and their relatives if they thought the care workers were caring and their responses were positive. Comments from people included, "The girls [care staff] are lovely, they always want to do that bit extra to help", "I am very happy with the care, I cannot fault the staff" and "There has been some slippage with the management, but the care has remained good."

Comments from people's relatives included, "The care staff do a sterling job in my opinion", "My mum has had other care agencies, but these girls are the best" and "The care is good, but the management side of things hasn't been clear lately."

Care workers treated people with dignity and respect. Staff we spoke with provided us with examples of how they maintained a person's dignity and offered respect. They told us about closing curtains and doors before providing personal care and making sure people were covered up as much as possible whilst personal care was provided. During our visit to a person's home we observed one care worker sitting with a person who was being cared for in bed. The care worker provided affectionate care to this person and spoke softly to them while holding their hand.

Staff spoke kindly when we asked them to tell us about people in their care. One staff member told us, "We develop good relationships with people and we are passionate about what we do." Another told us, "We do our best for people as carers, I think people appreciate the support we give to them." The staff also told us they tried to chat with people to take their mind of the task they were being assisted with.

Staff had developed caring relationships with people and demonstrated they knew people`s routines and preferences well. People told us they were offered choices and these were respected which helped people to feel they still retained their independence. For example people were able to say whether they wanted to have breakfast first then be assisted with personal care or what they wanted to eat and drink and what clothes they wanted to wear.

By speaking with care workers it was obvious that they knew the people they supported very well as individuals; they could describe people's likes, dislikes and preferences. Although we found people's care plans varied in the level of person centred detail, staff made the time and effort to get to know people and understand their needs. One person told us, "They know what I like and what I don't like", and relatives said, "They know [name] really well, they listened to what [they] like", and, "They've taken the time to get to know [name]." This showed us that care workers knew the people they supported well as individuals.

As part of our inspection we visited the offices of Sedgeborough House. We found that electronic and paper documents were stored securely and the appropriate checks were in place to ensure that confidentiality was maintained for the people using the service.

Requires Improvement

Is the service responsive?

Our findings

An initial assessment was completed before staff started supporting a person, and this and a list of tasks for staff to complete at each call were kept at the person's home and at the office.

Care plans should be personalised and contain a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. However, they varied greatly in detail and the two care plans we viewed required further detail to ensure that people received appropriate care and support which was consistent and safe, according to their wishes and that staff promoted people's independence.

Care plans were not personalised with detailed information about people's personal care routines, for example, care plans stated minimal information, such as, 'assist [the person] to get up and have a wash/shower', the information did not say what 'assist' meant to the individual or take into account people's medical conditions when they were being supported with their mobility. There was no guidance of how people were being supported to remain independent and show what they could do for themselves. Care plans did not contain any details of people's personal history so that staff would know about and be able to discuss things that were important to them.

There was a lack of guidance in care plans about how staff should give the right support. One care plan we viewed contained information about two people's care needs who were living together. Both people's information in this care plan was difficult to determine, as it didn't separate out what support was required by each individual. We found both care plans were stored in no particular order and difficult to follow. We found this was not person centred individualised care.

One person we visited was predominantly cared for in bed and was at risk of developing pressure areas. The risk of developing pressure areas had been identified but there was no plan to show staff how to manage people's pressure areas to minimise the risk of further outbreaks. The care plans did not contain information to inform staff on how to give care to people whose skin may be at risk of breaking down. There was no information about what signs to look for in case sores were developing and what action they should take, like contacting the doctor or community nurse. As reported earlier in the report CQC made a safeguarding referral due to these concerns. The provider did have a pressure sore management policy and procedure which was dated December 2013, which stated 'all service users will be assessed using the Waterlow scale and an appropriate plan of prevention care will be entered in the service users care plan'. We found this did not happen.

The provider had failed to ensure that care plans reflected people's assessed needs, preferences and current support needs so 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.

We were told that an initial review was undertaken four weeks after the start of a new care package to check that the needs of the person were being met. Following that reviews were then scheduled every three

months. We viewed a number of three monthly reviews. It wasn't clear from these reviews whether the registered manager discussed aspects of the care plan with people or the staff team, due to the limited information recorded from the documentation. We noted these reviews were mainly around the quality of the service and whether people were happy with the care that was provided. Given that we found that care plans are not person centred or reflective of peoples current care needs this review is not effective.

People had information about how to complain within the care plan folder kept in their home. This information explained how the registered manager would respond and act on any complaints that they received. People told us they felt confident in complaining, or felt a relative would complain on their behalf. One person said, "I would have no hesitation if I needed to complain, however all is fine so far." People said when they had complained action had been taken and the issue had been resolved. We saw no complaints had been made since the last inspection in March 2016.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager who was also the nominated individual; they had been registered with the Care Quality Commission (CQC) since April 2013. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to the inspection we were informed the registered manager was due to retire and the provider was actively looking to recruit a new manager. At the time of our inspection the registered manager had been asked by the director to assist with the inspection process, which she did. We were informed by the registered manager she had officially left Sedgeborough House on 14 July 2017, but assisted with the inspection process to help the director.

During the inspection the director informed us that she had taken responsibility for managing Sedgeborough House for the last two months, working alongside the registered manager until she left on 14 July 2017. However, during the inspection we noted the director did not have experience working in adult social care and had not undertaken any key training to ensure she was competent in her role. Shortly after the inspection we were informed by the director the registered manager had returned to her role as manager, until the provider recruits a new experienced manager.

At the last inspection in March 2016 we found breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not have effective systems in place to monitor and assess the quality of care records. At this inspection we found no improvements had been made.

We noted that following the last inspection the registered provider had not sent CQC their written report of the action they would take to meet the requirements of the Health and Social Care Act 2008. The requirement for an action plan to be sent to the CQC is stated in the letter accompanying the final inspection report sent to the registered provider. We found there was no action plan in place to rectify the issues found at the last inspection. We discussed this with the director who was not aware the registered manager had not responded to CQC from the last inspection.

We asked the registered manager what monitoring she undertook to ensure people were kept safe and received a quality service. We were provided with audits of MAR records and staff spot checks. We found these audits were not completed frequently and lacked detail of what was looked at. For example, the medication audits consisted of the registered manager signing the top of the MARs, and not indicating if any discrepancies had been found or followed up. We found the medication audits did not cover the storage of people's medicines, the risk assessments or the medication competencies of the staff. No other audits in relation to care planning, training, recruitment, and staff development had been undertaken.

At the last inspection in March 2016 we found the service did not have an effective system in place for the logging and following up of any incidents. This meant that the registered manager did not have oversight of

all the incidents and accidents that occurred at the service and therefore could not respond with corrective actions if necessary. We discussed this area with the director and found this was still the case. Any significant information was recorded in the office communication book. We noted there were still no formal mechanisms in place to monitor accident and incidents to establish any developing themes. We found staff had reported one person who had fallen in February 2017, we found the person received the appropriate medical treatment. We noted this was recorded in the office communication book, but no further action was followed up by the provider to check whether this fall could have been prevented or whether the person needed specialised equipment within their home. Accidents and incidents were not managed effectively to monitor trends and patterns or to reduce the risk of further accidents and incidents re-occurring.

During the inspection we asked the service to provide their business contingency plan. We were informed by the director the service did not have a plan in place. This meant that we were not reassured that the provider would be able to continue to provide a service to people and keep them safe in an emergency situation. For example, if the staff team were affected by diarrhoea and vomiting or an IT system failure. The contingency plan should outline what action would need to be taken for such, i.e. use of bank staff or another local agency.

We asked the provider if they had sent quality assurance questionnaires to people for feedback on how they felt the service was delivering care and how they could improve. The provider told us this had not been done yet. The provider had not assessed the feedback from people to see how improvements to the service could be made and no actions had been taken. Staff and professionals were not asked to provide feedback to the service.

The provider failed to ensure that systems were established and operated effectively both at a local level and at provider level to ensure compliance with the regulations. The governance systems and procedures in place to assess, monitor and drive improvement in the quality and safety of people were not effective.

The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. This was an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records relating to staff meetings. There had last been a staff meeting in April 2017. However the minutes we viewed did not include the people that had attended the meeting. We also found the meeting minutes for September 2016 did not include the attendees. We discussed this area with the director who assured us attendees would be included going forward.