The Lady Verdin Trust Limited

The Lady Verdin Trust - Claremont

Inspection report

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Date of inspection visit:
05 September 2017
07 September 2017

Date of publication:
13 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5 and 7 September 2017 and was announced.

The Lady Verdin Trust – Claremont, provides personal care for up to four people with a learning disability. At this inspection they were providing care and support for four people.

A registered manager was in post and was available to us during day one of this inspection. However, owing to pre-arranged annual leave they were not present during day two. 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.

At the last inspection the service was rated overall good. At this inspection we found the service was in breach of regulations relating to person centred care, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, staffing and governance. The service provider was also in breach of the regulation requiring them to display their rating.

People did not have their individual rights protected. This was because the provider did not understand and apply their requirements to appropriately assess and submit applications for the Deprivation of Liberty Safeguards.

The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment.

People did not have information presented to them in a way they understood preventing them from making fully informed decisions. People's individual capacity to make decisions was not assessed. As a result decisions were being made for people by the provider without the correct authority to do so.

People did not have effective, up to date or comprehensive care and support plans which reflected their individual needs. This put people at risk of inappropriate care.

The provider did not have effective quality monitoring systems in place to identify and respond to poor practice.

The provider had failed to display the previously rated performance.

People took part in a number of social and leisure activities, however, these were not extensive and there was little drive to increase people's abilities, skills and interests. Individual goals and aspirations were not identified or promoted.

People were not consistently involved in decisions or changes in their home. People were not asked for their views and the provider did not have systems in place to consistently obtain people's opinions.

People did not have up to date and accurate assessments of risk associated with their care and support. Assessments in place had not been effectively reviewed and did not account for changes in the person or their physical environment.

Staff members were not provided with specific training to enable them to support people with their individual needs

People were supported by enough staff to safely meet their needs. People received help with their medicines from staff who were trained to safely support them. The provider followed safe recruitment practices and completed checks on staff before they were allowed to start work.
The provider had systems in place to address any unsafe staff practice including retraining and disciplinary processes if needed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe 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 to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

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.
People did not have up to date risk assessments associated with their care and support. Staff members did not have guidance in place to assist them to support people safely.

The provider followed safe recruitment checks. Incidents and accidents were investigated in order to minimise reoccurrence.

Is the service effective?

Inadequate

The service was not effective.
People did not have their rights protected. Appropriate applications for the Deprivation of Liberty Safeguards had not been made.

Staff members were not provided with specific training to enable them to support people with their individual needs.

Staff members were not aware of people's specific dietary requirements. The information directing staff members regarding people's diets was inconsistent and contradictory.

People had access to healthcare to maintain wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always given the information they needed in a way they understood in order for them make decisions.

People had their dignity and privacy respected by those supporting them.

Information confidential to people was kept securely.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have accurate care and support plans that

reflected their needs.

People were not supported to identify or achieve their goals or aspirations.

The management team had systems in place to address any concerns or complaints.

Is the service well-led?

Inadequate

The service was not well led.
People were not always asked for their views or opinions and they were not consistently involved in developments in their home.

The provider was not fully aware of the requirements of their registration.

Quality monitoring systems were ineffective in identifying and responding to poor practice.

The Lady Verdin Trust - Claremont

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 5 and 7 September and was announced. The provider was given 24 hours' notice of this inspection. This was because the service provides care for younger adults who are often out during the day. We needed to be sure that someone would be in.

The inspection team consisted of one inspector.

We reviewed information we held about the service. We looked at our own system to see if we had received any concerns or compliments about the provider. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. We used any feedback received as part of our planning.

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.

We spoke with five staff members, two relatives, the service manager, the community service manager and the registered manager. We looked at the care and support plans for three people, risk assessments, records of quality checks and medicine administration. We confirmed the recruitment details of two staff members.

Requires Improvement

Is the service safe?

Our findings

People were not consistently protected from the risks of harm associated with their care and support. The provider did not have robust risk assessments in place. The risk assessments they did have in place were not reviewed regularly and did not contain up to date information. For example, one risk assessment made reference to the provision of "Stable style" doors leading into the kitchen area. This was to minimise the risk of harm to people when in the kitchen. We saw these doors had been replaced with regular doors which were open. We were told by staff this was for those living there to freely move around their home. We asked one staff member about the doors. They told us, "I think the doors went a couple of years ago." The provider had not reviewed or adapted the risk assessment to account for this change. There was no information on how to safely support people in the kitchen area following the removal of their previously identified risk controls.

Other risk assessments we saw had not been reviewed for several years. For example, one risk assessment regarding access to the community had not been reviewed for over four years. We saw that in each person's individual care plan there was a signing sheet for staff. This was to state that they had read and understood the risk assessment. On all of the signing sheets we looked at only two staff members had signed to say they had read and understood the information provided. However, staff we spoke with were able to tell us what they did to keep people safe. One staff member said, "We make sure the areas are kept clear and remove any tripping hazards we see. This is so people do not fall and injure themselves." The understanding of staff members was generic in terms of general risks associated with peoples care and support. However, they were not provided with guidance on how to safely support and meet people's specific and individualised needs. For example, there was no guidance on how to maintain a safe environment for those living with a visual impairment.
These concerns are detailed further in the responsive section in this report. However they form a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had individual emergency evacuation plans in place. These plans detailed for staff and the emergency services the support people would require during such a time.

We saw that there were enough staff to meet the needs of those living at Lady Verdin Trust – Claremont. However, staff and relatives told us they thought more staff were required to engage people in social activities. One relative said, "I would like [person's name] to get out more and just get some fresh air. I know they have had difficulty with staffing but having an extra person just to get people out would be better." The community service manager told us that they had to utilise agency staff members to support the staff team. They further told us they had recently recruited new members of staff and they were due to start work shortly.

Staff members we spoke with told us that before they were allowed to start work checks were completed to ensure they were safe to work with people. Staff told us references and checks with the Disclosure and Barring Service (DBS) were completed and once the provider was satisfied with the responses they could

start work. The (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with others. The provider had systems in place to address any unsafe behaviour displayed by staff members which included disciplinary action if required.

We looked at how people were kept safe from abuse. Relatives we spoke with told us they believed their family members were protected, one relative said "I know [person's name] is safe and they trust the staff supporting them." Staff we spoke with could tell us what abuse was and what they would do to raise any concerns they had. One staff member said, "I would tell [support manager's name] straight away. If not I could always phone the police." We saw information was available to staff on how to report abuse. We checked with the registered manager and they confirmed they had not needed to make any referrals to the local authority in order to keep people safe. However, they did have procedures in place should they need to do so.

We saw incidents and accidents were recorded and reported. Any incidents were monitored by the registered manager in order to see if any additional actions were required. All incidents and accidents were then passed to the provider's health and safety representative. The registered manager told us this was for any additional guidance that may have been needed. They went on to say that they had not received any additional advice on any of the accidents reported. However, they did have systems in place to identify any trends and patterns.

People received their medicines when they needed it. We saw staff supporting people to take their medicines when they required. One staff member told us, "We complete our training on medicines and are then watched to make sure we do it right." We saw one staff member identify a signature had not been made in one person's medication administration record. They ensured the person had received their medicines and that this was an administration error.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. It was not. People did not have current or decision specific assessments of capacity in place. For example, the provider had responsibility for managing people's finances. However, there was no information available to indicate if the person had the mental capacity to manage their own finances or not. In addition there was no information available to indicate if people could consent to receiving medicines. The provider was making decisions on behalf of people without following recognised guidance or best practice.

We did see one example of a best interest decision that had been made regarding the consent for treatment. This had had been led by the local authority. However, one staff member told us about the process they would follow if someone needed to make a significant purchase in their best interests and who they would discuss this with. The staff member understood the principles of best interests and capacity but did not have the supporting systems in place to ensure decisions made were lawful or followed the principles of The Mental Capacity Act 2005. Therefore, in relation to this purchase, there was no specific assessment in place to state that the person could not make the decision themselves.

We saw staff members engaging people and seeking their permission before supporting them. One staff member was sat chatting with one person talking about what they wanted to do and what support they needed. Another staff member supported someone to choose what they wanted for breakfast and where they wanted to sit. We asked staff how they understood what people had decided. A staff member said, "We know people's facial expressions and gestures. We can see if they turn away from us or gently push us away that this is quite obviously a no. Other signs are more subtle and can involve a noise. One person can clearly tell us if they like something."
However, there was no individual communication profile or written documentation on how to encourage and promote individuals' communication. One staff member told us, "I suppose it would be useful if we all wrote down how people communicate with us. That way everyone would be aware of the individual habits people have developed." One relative said, "[Relative's name] has some adapted signs. The staff know what they are but I have never seen them written down anywhere." People did not have personalised communication profiles which took account of their preferred methods of communicating. This, along with the lack of understanding regarding the mental capacity act meant that people were not fully involved in decisions regarding their care and support. People living at the Lady Verdin Trust – Claremont, did not have their rights under The Mental Capacity Act 2005 protected.

These concerns form a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff members we asked told us that everyone living at The Lady Verdin Trust – Claremont was subject to a (DoLS). The files we saw did not contain any information regarding any such applications or approvals. We asked the community support manager who was currently being safeguarded as part of (DoLS). They told us all four people were but they could not locate the relevant paperwork. They informed us this information was located at their head office.

We visited the head office with the community support manager and met with the registered manager. We were shown one incomplete application regarding one person. This application was dated January 2015 and did not have an assessment of capacity supporting it. We did see an assessment of capacity regarding consent to live at The Lady Verdin Trust – Claremont, but this was dated May 2015 and several months after the initial application had been made.

Following the making of the incomplete application the provider did not instigate any contact with the placing authority to confirm the status of their application. The registered manager told us they believed this initial application had sufficed. There was little or no understanding about the application process. In addition, neither the registered manager, or community support manager, understood the review process or their need to resubmit applications after the relevant time periods had expired. There was no information available about any such applications or authorisations for the other three people living there.

As part of the provider information return, completed August 2017, we asked, "How many people who currently use your service are subject to authorisation under the Deprivation of Liberty Safeguards?" The registered manager, in their response in August 2017, informed us that four people were. At this inspection we found this information to be incorrect. One application had been made and this had expired in January 2016 without any additional action by the provider. This meant people were unlawfully deprived of their liberty.

These concerns form a breach of Regulation 13: Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with told us they believed that the staff supporting their family members had the correct training and skills to effectively work with people. One relative said, "I think they are all OK, some are better than others but everyone knows how to look after [relative's name]. Staff we spoke with told us they received an induction to their roles when they first started work with The Lady Verdin Trust - Claremont. This included initial training which comprised of health and safety and first aid. New staff members also had the opportunity to work alongside other more experienced colleagues. One staff member told us, "I got to know people and find my way around before working directly with them."

Staff members had differing experiences regarding additional training appropriate to their role. One staff member told us they had been supported to achieve their Care Certificate. The Care Certificate is a nationally recognised training programme aimed at training staff to recognise the standards of care required of them. Another staff member told us that they had completed the work towards their certificate but they did not understand what had happened regarding its accreditation. They told us the person responsible for the training had left the provider's organisation and no one had replaced them. They told us they have asked repeatedly for information but have given up asking as "No one seems to be sorting it. Everyone seems to be too busy to look at our training." We asked staff members about specific training to enable them to support people effectively. One staff member told us, "No one seems to have had any training on visual impairment or how to support someone who is blind. This is a big worry for me as we do support people with visual impairments." Staff members were not provided with specific training to enable

them to support people with their individual needs.

These concerns form a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff had differing experiences regarding their training overall they felt supported on a day to day basis by the management team. Staff members we spoke with told us they received support from the management team and colleagues. One staff member told us, "I get regular one-on-one sessions with [community support manager's name]. I can talk about what is important to me and my work and those I support." All the staff told us how valued their colleagues are and how they supported one another in their day to day work with people. One staff member said, "We are a very tight team here and all talk and help each other out when it's needed."

We saw staff sharing information appropriately between people they supported and other staff members. We saw staff members exchanging information on what support people had received and what was still required to meet their needs. For example, we saw staff talking with one another about contact with the GP and what information was needed.

People had access to healthcare services, including doctors and specialist interventions for specific medical conditions when needed. People also had access to opticians and chiropodists in order to maintain good health. Relatives told us staff responded to changes in people's health condition. Assistance was requested from medical professionals and guidance recorded to support people appropriately.

We saw people being supported with meals by staff who were patient and encouraged people to eat. Relatives told us they believed their family members had enough to eat and drink to maintain their health. However, we saw inconsistencies in the information provided to staff regarding people's diets and their specific needs. Staff were not aware of information contained in people's care and support files that instructed specific diets for people. For example, staff were not aware of a high fibre diet or to avoid spicy foods for one person. This meant that people did not receive the assistance they needed to maintain healthy eating and drinking.

Requires Improvement

Is the service caring?

Our findings

People did not have information available to them in a way that supported their decision making. For example, one person's care and support plans made reference to objects that could be used to engage them with their communication. However, there was no indication what these objects were, what they could assist with or how staff should use them to encourage people's decision making. One relative said, "I know they (staff) know [relative's name] well but some of their own particular signs are not recorded anywhere. I am not asked for my input into them. I fear they may lose them if staff don't support them properly."

Staff we spoke with told us that no one living at The Lady Verdin Trust – Claremont had any involvement with an advocate at the time of this inspection. We saw information was on display in a staff area but this information was not readily available to anyone living at the location. One staff member said, "If we need to, we will get an advocate involved or include their family."

Relatives described staff as, "Good," "Kind," and "OK." The relatives we spoke with talked about the staff members with regard and believed their family members were supported in a caring environment.

At this inspection we saw interactions between staff and people. We saw staff sitting and chatting with people and engaging them with things that staff members knew they were interested in. For example, we saw one staff member talking with someone about a particular television channel and what was on.

We saw staff provided reassurance to people at times which could potentially cause them alarm and distress. One person had a caused a small injury to one of their fingers. One staff member recognised this immediately and went and sat with them. After a while the person allowed the staff member to look at their finger. The staff member put the person at ease and after gaining a gestured agreement from them supported them with a plaster. The staff member made a game of applying the plaster in order to alleviate any anxiety the person may have been experiencing.

We saw people making day to day care decisions. This included what they wanted to wear and what they wanted to do and eat. One staff member told us, "Those living here can make some small decisions and this is what we can ask them and engage them in. However, anything else more complex and we refer to the management team."

People had their privacy and dignity respected by those supporting them. We saw staff members knocking on doors and waiting for a response before entering people's rooms. We saw people being asked their permission before staff members assisted them. For example, one staff member asked a person if they wanted to change position and move away from the table. When the person indicated they were in agreement the staff member supported them.

Information which was confidential to the individual was kept securely and only accessed by those with authority to do so. We saw that prior to disclosing information staff members confirmed people's authority to access people's personal details.

Inadequate

Is the service responsive?

Our findings

We found people's care and support plans were not up to date and did not reflect their current needs or preferences. For example, one person's care plan made no reference to their visual impairment. Another plan did not account for the person's deteriorating sight and a third had contradictory information regarding the person's health and diet. One person's care and support plan stated that staff must engage them with physio exercises each evening. In another section of their file it stated this should be completed three times per week. However, there was no information about what these exercises were or how staff could support the person safely whilst assisting them with their exercises. For one individual their "all about my health" and "hospital passport" documentation was blank and no information was available for staff on how to support them to meet their needs.

The community support manager told us they regularly reviewed people's care and support plans. However, those we looked at only contained a signature to say there had been a review but none of those we looked at contained any changes or updates. We looked at one person's care plan for the use of their hoist and subsequent transfers. This plan was created in March 2011. There was no date indicated for review. No review had been completed from the creation of this plan up to the time of our inspection. We asked staff members if they were indeed aware of any changes in people's needs. One staff member told us how this person's mobility and sitting position had changed to such an extent that they now required different mobility equipment to account for their changes. They were in the process of assessment and had trialled a new piece of equipment. However, these changes in mobility or positioning were not accounted for in any of the care and support plans we saw. We asked staff if this was recorded elsewhere but those we spoke with informed us if it was recorded it should be in the person's care and support plan. The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment.

These concerns form a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were confused regarding who wrote the care and support plans for people. Some thought the community development manager completed these and others thought the registered manager completed them. One staff member told us they had supplied up to date information regarding one person's changes to mobility but this had never been incorporated into their care plan. A staff member told us, "There really is little point reading them. What we do is talk amongst ourselves and if there is any changes we tell each other."

Staff members told us they did not routinely read these care plans as they recognised they were out of date. Each care and support plan had a staff signature sheet. This was an indication that staff members have signed to say that they have read and understood the person's care and support plan. However, these signature sheets only contained two signatures. There were no assurances that staff members read and understood people's care and support plans. Care records were out of date and that they did not sufficiently guide staff on people's current care, treatment and support needs; this puts people at risk of inappropriate care.

These concerns form a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with were knowledgeable about those they supported. They could tell us all about the people they supported, their families, things they enjoyed and what their support needs were. We asked staff how they knew this information when they were aware that the information in the care and support plans was out of date. They told us it was because they all shared information informally between one another. If there were any changes this was passed on from staff member to staff member. However, this informal system of information sharing with little managerial oversite resulted in important pieces of information being missed. For example, contained in one person's medical passport was information relating to a specific stomach complaint and a specific diet for the person to follow. None of the staff member we spoke with were aware of this information. The support people received did not follow specific instruction from medical professionals in order to meet their needs.

None of the relatives we spoke with told us they were routinely involved in the review of their family member's care and support plan. One relative said, "I think I was once asked but this is going back many years. It is not something I am really asked about. However, if I have an opinion I will raise it with [community support manager's name]."

None of the care and support plans that we looked at contained information that had been presented in a way that made them accessible to the person it related to. For example, no information was presented in an easy to read format or a larger font for those with reduced sight. The only examples we saw of accessible information had been information provided by local NHS Trusts.

As part of the provider information return completed by the registered manager in August 2017 they informed us that staff supported people in identifying and attaining their individual aspirations and goals. They said, "Staff are all trained to follow the SMART objectives when supporting our clients with planning their goals, therefore all goals are specific, measurable, attainable, realistic and timed." At this inspection we did not see any objectives to support people's development. One person had a goal to have their bedroom floor replaced. However, this was not a personal aspiration but an essential maintenance task. This goal had been identified three months prior to this inspection. We asked the community support manager how they were progressing with this goal. They told us, "We are still waiting for quotes." We asked who had over site of this goal to ensure it is completed in a reasonable time. Unfortunately the community support manager was unable to answer this for us. People were not effectively engaged with identifying or achieving their goals and aspirations.
These concerns form a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.and regulation 17

At this inspection we saw that people were involved in a number of activities to keep them occupied. This included attendance at day centres, swimming and going to the gym. However, staff and relatives told us that owing to recent staffing difficulties activities had been difficult to complete with people. One relative told us how it would be nice if their family member could engage in activities they used to enjoy, for example going out on public transport. They told us they understood the difficulties and were hopeful these activities would start again shortly.

People were encouraged to maintain relationships with those that mattered to them. Relatives and friends were free to visit whenever they wanted and private areas for visiting were available if they wished. One relative told us that owing to their personal circumstances it was difficult for them to visit their family member. They said, "The staff are very good. They will always bring them to see me and stay and support us

during the visit." Relatives we spoke with told us that if there were any changes or concerns they were contacted immediately by staff and kept fully informed.

Relatives we spoke with told us they had not needed to raise any concerns or make any formalised complaints with the provider. One relative said, "If I did have a concern I would phone the home or [community support manager]." The provider had systems in place to respond to and investigate complaints. However, we did not see any information available for people living at Lady Verdin Trust – Claremont in an assessable format for people to understand and follow if they needed. The registered manager and community support manager told us that they had not received any complaints in the 12 months prior to our inspection.

Inadequate

Is the service well-led?

Our findings

The provider did not have effective quality and monitoring systems in place to identify improvements that may be required in the care people received. The registered manager told us that a recent service planning and delivery assessment had been completed by their partner care provider. However, this piece of work was not dated and we could not ascertain if it was current or not. The registered manager told us that as a response to this piece of work they had to develop an action plan. However, at this inspection they had yet to identify the actions they would be completing and the action plan remained blank. We asked the registered manager and the community support manager if any other quality checks had been completed. They could not provide us with any.

When we fed back our findings from this inspection the registered manager and the community support manager told us that they were "not surprised" at our findings or concerns. They indicated that they were aware of the improvements that were needed but could not indicate what they had done when they first became aware of them.

At our last inspection in 2015 we identified concerns regarding the out of date care and support plans. Following this inspection the community support manager contacted us and stated, "[registered manager's name] and [community service manager] are going to Claremont on Monday morning to look at Support Plans and Risk Assessments, with a view to re writing them with staff input." At this inspection many of the care and support plans had not been re-written or effectively reviewed as evidenced at this inspection. The care and support plans and risk assessment alluded to in this response still predated our last inspection.

People were not routinely engaged in decisions about where they lived. They were not approached for their opinions or views about the care and support they received. Relatives we spoke with told us they had not been contacted by the provider and asked their opinions regarding The Lady Verdin Trust – Claremont.

The registered manager told us a survey of those that used the services of The Lady Verdin Trust had been completed in 2016. We were shown a copy of the results of this survey when we visited the head office. However, the registered manager could not confirm with us if anyone from The Lady Verdin Trust – Claremont, had been engaged as part of it. None of the families we spoke with were aware of this survey or its results. We did not a see copy of this survey anywhere at The Lady Verdin Trust – Claremont and none of the staff we spoke with were aware of it.

People and relatives were not regularly kept informed about changes to the provider's organisation or things that may affect them of their family members. One relative said, "I don't think I have ever seen a newsletter or any information about any changes." The registered manager told us that they were merging with another care provider and that this had been ongoing for the last couple of years. The provider information return completed by the registered manager told us about the changes to the management structure and the introduction of new care and support plans for people. However, none of the relatives we spoke with were aware of any of these changes and one was very surprised to find another care provider was involved with their family member.

Staff members told us the support manager; community support manager and the registered manager were approachable although they rarely saw the registered manager. One staff member said, "We don't have very many staff meetings. These have sort of slipped away." We asked that when these meetings did occur if they had access to minutes if they wanted. One staff member said, "I think [community service manager's name] makes notes but I have never seen any written up of left for us to read." Staff members we spoke with were aware of the policies and procedures that impacted on their practice including the whistleblowing policy. One staff member said, "I am sure I would be supported if I needed to tell someone something, but that has never happened."

These concerns form a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day one of this inspection the provider had failed to display its previous rating as required at each premises from which the service provides a regulated activities. We brought this to the awareness of the registered manager and the community support manager. On day two of this inspection the rating was displayed at location as required. Neither the registered manager nor the community support manager was aware of the requirement to display ratings when we asked them.

These concerns form a breach of regulation 20A (requirement to display) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Lady Verdin Trust – Claremont, had links with the local community. People attended local facilities including, day centres, leisure centres and places of interest.

The Lady Verdin Trust – Claremont had a registered manager in place. The registered manager understood some of the requirements of their registration with the Care Quality Commission but not all, as indicated above.

We observed a certificate of registration issued by the Commission for Social Care Inspection in 2004 was displayed at The Lady Verdin Trust – Claremont. We enquired with the community support manager why they were displaying such a certificate as this particular registration organisation ceased to exist in 2009. The community services manager then asked "Well - who do we register with?" They followed this by asking, "Who should be telling us these things?" Albeit the registered manager was aware of most of the requirements of their registration with the Care Quality Commission. Any delegated responsibilities for example, quality monitoring, was not being undertaken by individuals who were keeping themselves up to date with current practice.

The registered manager understood their requirement to submit notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. However, in the 12 months prior to our inspection they had not needed to make any such notifications. The registered manager took responsibility for maintaining their knowledge and skills with regular attendance on training courses provided.

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 Care and support plans had not been reviewed for a significant period of time and did not reflect peoples current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Individuals capacity to make specific decisions had not been assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks of harm associated with people's care and support had not been assessed or reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not understand and apply their requirements to appropriately assess and submit applications for the Deprivation of Liberty Safeguards.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not completed effective quality monitoring checks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff members did not have access to training essential to meet the needs of those they supported.