Creative Care (East Midlands) Limited

The Old Vicarage

Inspection report

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

Summary of findings

Overall summary

The Old Vicarage is a Georgian property near Ironville with a large secure garden area. People live in three separate buildings, known as the main house, the bungalow and The Stables (a modern stable conversion). There is a secure courtyard and garden space shared by all three buildings. The Old Vicarage is registered to provide accommodation for nine people who require nursing or personal care. The service does not provide nursing care. At the time of our inspection there were eight people living there. Four people were living in the main house, and three people lived in the bungalow. One person lived in The Stables. The Old Vicarage supports younger people who have diagnoses of moderate to severe learning disabilities and other complex healthcare needs.

We previously carried out a comprehensive inspection of the service in February 2016, when The Old Vicarage was rated as Good. Following concerns from local authorities and a whistle-blower about the quality of care provided, this comprehensive unannounced inspection was carried out.

People were not kept safe from the risks of avoidable harm and abuse. People were not kept safe from the risks associated with unsafe physical restraint. Risks associated with the environment were not reduced and mitigated. Information about people's care needs in an emergency were not up to date or easily accessible. Medicines were not stored securely.

Staffing levels were not consistently sufficient to ensure people received the care and support they were assessed as needing. The provider did not always undertake pre-employment checks to ensure prospective staff were suitable to work with people receiving care.

People were at risk of harm because staff did not have training to help them to understand how to effectively support people's health and care needs. The provider could not assure themselves that staff had training and skills to meet people's needs.

People were at risk of being physically restrained when this was not proportionate or in their best interests. There were no effective safeguards in place to ensure physical interventions used were minimal and reasonable. The provider was not working in accordance with the Mental Capacity Act 2005, and people were at risk of care that was overly restrictive and unlawful.

People's health action plans were not kept updated with information about health appointments and outcomes. There was a risk that essential information would be lost and not shared appropriately, and people would not receive the healthcare they needed. The provider could not demonstrate that people were supported to maintain their health.

Staff spoke in a caring way about the people they supported, but this was not consistently reflected in their actions or language. People were not consistently supported to participate in designing or reviewing their care. People's confidential care records were not kept securely.

People did not receive personalised care that was responsive to their needs, preferences and aspirations. People were not supported to communicate effectively. There was no effective system in place for people or relatives to share their concerns and contribute to improving the service.

The service was not managed well. There were failures to meet the fundamental standards in relation to safe care practices and staff recruitment processes, insufficient staffing levels and staff training, planning and delivery of people's care, and following relevant legislation. Systems and processes in place did not identify learning from incidents and mitigate any future risks to people. Quality assurance processes to ensure people's care and the service environment were safe were not effective. CQC registration requirements were not being met.

The Old Vicarage had a registered manager, and they were present during our inspection. 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.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to these concerns found during inspection is added to reports after any representations and appeals have been concluded.

We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

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.

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.

People were not kept safe from the risks of avoidable harm. There were not enough staff to meet people's needs. Risks associated with the environment were not reduce and mitigated.

Is the service effective?

Inadequate

The service was not effective.

Arrangements for induction, training and supervision did not develop staff skills to meet people's complex needs. The provider was not working in accordance with the Mental Capacity Act 2005, and people were at risk of care that was overly restrictive and unlawful.

Is the service caring?

Requires Improvement

The service was not caring.

Some staff practice had developed that did not demonstrate caring values. People were not consistently supported to participate in designing or reviewing their care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive personalised care that was responsive to their needs. People were not supported to communicate effectively. There was no effective system in place for people or relatives to share their concerns and contribute to improving the service.

Is the service well-led?

Inadequate

The service was not well-led.

There were failures to meet the fundamental standards in relation to safe care practices. Quality assurance processes to ensure people's care and the service environment were safe were not effective.

The Old Vicarage

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.

The inspection took place on 11, 18 and 19 April 2017 and was unannounced. The inspection team consisted of two inspectors on 11 and 18 April, and one inspector on 19 April 2017.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, incidents resulting in serious injuries, or allegations of abuse. We spoke with the local authority commissioning teams, and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. They raised concerns with us about staffing levels, training and the level of safeguarding incidents at the service.

During the inspection we spoke with two people who used the service and two relatives. We spoke with eight staff, the deputy manager and registered manager. The provider had recently employed a new manager for the service, and we also spoke with them. We also received the views of five social care professionals. Not all of the people living at the service were able to fully express their views about their care. We spent time observing how people were supported by staff in a range of activities during the three days of our visit. We looked at a range of records related to how the service was managed. These included five people's care records, three staff recruitment and training files, and the provider's quality auditing system.

Inadequate

Is the service safe?

Our findings

People were not kept safe from the risks of avoidable harm and abuse. Information we held on the service indicated there were a high number of safeguarding notifications to CQC. Six notifications related to incidents where people had been physically harmed by staff. Although each incident had been dealt with appropriately, the provider could not demonstrate how lessons had been learnt to reduce the risk of avoidable harm in the future.

People were not kept safe from risks associated with the environment. During our inspection visit, we identified concerns about locked external doors. Staff said this ensured people did not leave the service without support. Not all staff on shift had keys to unlock these doors. Staff could not quickly identify which key was required for each door. We spoke with the registered manager about this. They said the provider was looking at installing a different door locking system, but this was not in place at the time of our inspection. This meant there was a delay in unlocking doors and exiting the building, which put people at risk in the event of a fire or other emergency.

The registered manager told us they had identified fire doors at the service which were not compliant with relevant regulations. They had also noted the window restrictors in the main building were not secure. These were designed to prevent people falling from windows. We saw evidence the registered manager had raised this with the provider, but no action had been taken to resolve this. This put people at risk in the event of a fire, or in the event window restrictors were undone.

The provider did not take action in a timely way to ensure safety features of the building were compliant with relevant legislation. Following discussion about concerns associated with fire prevention mechanisms in the building, we passed our concerns to Derbyshire Fire and Rescue Service.

People were not kept safe from risks associated with unsafe physical restraint. Risk assessments and care plans in relation to the use of restraint did not contain sufficient information to ensure people were kept safe. There were no accurate guidelines for staff to refer to, which could reduce the likelihood of restraint being used when supporting someone who was experiencing heightened anxiety. For example, one person's support and behaviour plan stated, "If staff feel [person] is escalating they are to follow the Pro-Active/Re-Active support strategies stated in the support plan." Their plan did not have any information about what these strategies were, or how staff should use them. Records confirmed this person had been restrained 17 times over a seven week period. There was no clear analysis of the episodes of restraint to establish whether less restrictive support could have been used. The provider's policy on the use of physical intervention clearly stated risks should be identified and clearly documented. This put people at risk of harm from restraint techniques which were unsafe.

People were not kept safe from risks associated with unsafe moving and handling techniques. Staff told us they did not feel they were using the correct techniques to move one person in a safe way, and said there were times when there were not enough staff available to do this safely. A professional said staff were not using techniques safely, and they had raised this with management. They said practice had not changed as

a result. Staff confirmed support to move the person was done with two staff, and we saw this during our inspection. A risk assessment stated the person needed three staff to support them to transfer from a chair to a wheelchair, but their care plan said they needed two staff. Staff told us, and we saw they supported the person in accordance with their care plan, but the risk assessment had not been updated to reflect the person's current needs. This meant staff did not have clear or consistent guidance about the level of support the person needed to move and transfer safely. The risk assessment did not identify how the person should be supported when transferring in and out of bed. There was no specific guidance for staff to identify what safe techniques should be used. The registered manager told us staff had received recent training in moving and handling, and felt there were enough staff to be able to do this safely when required. The evidence demonstrated staff were not moving the person in a safe way, and there were times when there were not enough staff available to move this person in the way described in the risk assessment. This put the person at risk of harm when they were supported to move incorrectly.

Information about people's needs in an emergency was not up to date. For example, one person had two documents to help hospital staff understand what their needs were. One document had been updated on 25 January 2016 and the other had not been updated since 28 January 2015. Neither document referred to the person's current health needs regarding epilepsy medicine, or their mobility needs. Each person had a personal emergency evacuation plan (PEEP) which contained information on how to support each person to remain safe in the event of an emergency. PEEPs were focused on fire safety equipment, with information about people's needs coming secondary to this. This meant there was a risk that essential information to ensure people's safety was not easy to find, and the information was not up to date.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were not consistently sufficient to ensure people received the care and support they needed. Whilst there were sufficient staff available to meet people's needs during the inspection, evidence demonstrated there were times when this was not the case. Staff told us there were times when there were not enough staff to meet people's needs. One staff member described concerns about having only one staff on night shift in the bungalow. They said one person living there needed two staff to support them to move and transfer safely, and another person would need two staff to support them in an emergency. Social care professionals expressed concerns about the levels of staffing at the service, describing times when people were not receiving the individual support they were assessed as needing to take part in planned activities. For example, on 6 April 2017, between 2.30pm and 10pm there were two staff on shift. Staff had recorded, "Only two staff on shift. No cover for third person." This was not enough to provide 1-1 support for 2 people and shared support hours for the third person. Based on people's assessed needs at night, staff told us and records demonstrated there were not always enough staff at night to meet people's needs.

Two people had shared support hours. The provider could not describe or demonstrate how the staffing was arranged for this shared support to ensure other people were not left without their 1-1 or 2-1 support. Evidence from a local authority contract monitoring visit on 9 March 2017 showed concerns about one person not receiving 2-1 support as they should. The registered manager had confirmed the person received 2-1 support, and said staff had not completed the records accurately.

A third person needed two staff to support them in the community. Staff told us they did not always do this. One staff member said, "Everyone [staff] does their own thing and finds out what works. We try to follow people's care plans but find what works for us." On 2 April 2017, this person's risk assessment and care plan was not followed, and they were left supported by one staff in the community. Evidence showed staff did not support the person as required, and the registered manager confirmed this was the case. The incident

resulted in restraint being used on the person which placed them and others at risk of harm.

The registered manager confirmed there had been issues with staffing, with staff leaving in the last year. The provider could not consistently demonstrate there were sufficient staff on shift to ensure people's needs were met.

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

The provider did not always undertake pre-employment checks to ensure prospective staff were suitable to care for people. Records showed, and the registered manager confirmed two staff started work without a completed Disclosure and Barring Service check. A DBS check helps employers to see if a person is safe to care for people. The registered manager took immediate action. However, at the time of our inspection, the provider had not undertaken pre-employment checks as required.

Medicines were not stored securely. Keys to the medicine storage area were not kept securely. There was a risk medicines were accessible to people and visitors to the service. We spoke with the registered manager about this and they assured us they would take action to remedy this. People received their medicines as prescribed. Medicines were managed safely and in accordance with professional guidance. Staff told us and records showed they received training and had checks to ensure they managed medicines safely. The provider had up to date guidance for staff which was accessible for staff who dealt with medicines.

Inadequate

Is the service effective?

Our findings

People received care from staff who did not have the skills or training to support them effectively. Staff told us, and feedback from whistle-blowers said there were concerns amongst the staff team about their ability to manage people's behaviour in safe and effective ways. Feedback from external professionals supported these concerns.

The induction process for new staff was not sufficient to ensure staff had the skills to support people effectively. Staff told us they spent two days learning about people's needs, the provider's policies and procedures, and shadowing colleagues before they had their first shift. We observed new staff during their shadowing and induction. They spent time reading policies and people's care records, although we saw little shadowing took place. One new staff member told us they had read and understood two people's risk assessments and care plans in a short period of time. The information they gave us demonstrated they did not have sufficient knowledge of those people's care needs. This staff member had not done training in safe moving and handling, or the safe use of restraint and said they would be starting work without this training. Another member of staff said, "We have a little book [recording induction and training] and fill it in as we go along. It needs to be filled in within six months." The provider confirmed this was evidence that staff were completing the Care Certificate. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that unregulated health and social care workers should adhere to. The provider's policy required staff to complete an induction programme, and have this reviewed by a manager to ensure they were competent and knowledgeable about providing care. There was no evidence that the skills and knowledge of new staff had been reviewed or assessed since they started in December 2016. We spoke with the registered manager about this, and they confirmed they had raised concern with the provider about the induction and training staff received before starting work.

People were at risk of harm because staff did not have training to help them understand how to effectively support people's health and care needs. For example, not all staff had received training in epilepsy and how to safely support people who experienced seizures. Staff were not always able to describe or name the type of seizures people were known to have. Staff told us they had training in supporting people with autism, but records did not support this. This meant people were at risk of inappropriate or unsafe care from staff who did not understand their health needs.

The provider required all staff to undertake training in techniques to cope with behaviour that may harm the person or others. This training included the use of physical restraint as a last resort. The training was reduced by the provider from four days to two days. Staff said this was not sufficient to give them confidence to support people whose behaviour was escalating. One staff member said, "We don't have enough training; we do [restraint] annually – could do with it more often." Staff told us and documentation demonstrated that restraint holds used by staff were unsafe. Staff said, and records showed they started supporting people before having this training. Not all staff had training the provider required before supporting people. The provider's policy stated only staff who had attended appropriate training should use physical intervention techniques. We had been notified of four incidents where inappropriate restraint had been used and people had sustained harm as a result. The provider had taken appropriate action to deal with each incident.

Evidence demonstrated that people were at risk of harm from staff who used restraint without appropriate training, and of inconsistent staff responses to behaviour which challenged them.

Staff said they received training in the safe moving and handling of a person with specific needs. However, they told us they did not feel confident the skills they had learnt were suitable or safe for the person. Staff told us and records confirmed the provider did not undertake any checks to assure themselves staff knew how to use safe moving and handling techniques. The provider could not assure themselves that staff had training and skills to meet people's needs.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no effective safeguards in place to ensure the physical interventions used were minimal and reasonable. A staff member said, "We don't have a de-brief; we find it difficult to spend time together – to learn from the incidents." Whilst records of individual episodes of restraint were reviewed by the registered manager, there was no wider analysis of people's behaviours, whether the use of restraint was necessary and proportionate, and whether lessons could be learnt to improve people's care. The provider's policy on the use of physical intervention clearly stated, "A positive, proactive non-aversive approach must always be used, with physical interventions considered a last option to protect the service user and others." People were at risk of being physically restrained when this was not proportionate or in their best interests.

Sensory rooms are relaxing spaces that help reduce agitation and anxiety, and can also be used to engage people, stimulate reactions and encourage communication. We found evidence that these rooms were not being used correctly. The sensory room in the main building was being used as a "time out" area for people who were angry or distressed, rather than being a sensory resource that was used in a planned and constructive way. The sensory room in the bungalow was being used as storage space for equipment, so was not available to people there. Staff told us, and records showed the room in the main building was often used for people whose behaviour was challenging to staff, where they were directed to the sensory room to "self-calm". Self-calming techniques are used by people to help reduce anxiety or distress. There was no clear guidance for staff on how the sensory rooms should be used. Staff did not have information about what self-calm was and how people were supported to develop the skills to do this. There was a risk people would view the sensory room as a punishment, rather than a resource to help them reduce distress or anger.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had sought authorisations appropriately for people. However, the provider could not demonstrate that the restrictions in people's care were regularly reviewed to ensure they complied with principles of the MCA. The provider was not working in accordance with the MCA, and people were at risk of care that was overly restrictive and unlawful.

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

The provider did not follow the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped

to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The provider could not demonstrate that best interest decisions had always been taken in accordance with the MCA. For example, there was no evidence relatives were involved in best interest decisions (where we knew relatives were involved in people's lives). Mental capacity assessments did not clearly identify what the specific decision was that needed to be made. There was no evidence of assessment of people's capacity or best interest decisions in relation to the use of physical interventions and restraint. This meant there was a risk that restraint was not being used in people's best interests.

The provider could not demonstrate staff attended regular supervision meetings to review their performance and discuss training needs. When asked about supervision a staff member said, "Supervision – don't think I have – unless it was part of the probation – or maybe only a mini-session." They said, "Staff don't seem to have that sort of supervision." The provider's policy stated staff should have monthly supervision, but the registered manager could not evidence this was taking place as required. The provider did not have consistent evidence that they assessed and reviewed staff skills and knowledge. This meant the provider could not assure themselves staff were able to put training into practice to provide effective care.

People's health action plans were not kept updated with information about health appointments and outcomes. For example, there was no evidence that one person had attended dental and optician appointments since 2015. Staff assured us they had attended these appointments, but could not provide evidence to support this. Although staff generally had knowledge of people's health needs, this was not always accurate or up to date. For example, the same person's specialist eating and drinking advice was referenced in their care plan, and guidance was available from the person's speech and language therapist for staff to access. We saw staff provide the person with food that did not follow the specialist advice. This put the person at risk of choking. Key information about people's current health needs was not included in care plans. Staff could not access relevant information about people's health appointments and associated key information about their changing health needs. There was a risk that essential information would be lost and not shared appropriately, and people would not receive the healthcare they needed. The provider could not demonstrate that people were supported to maintain their health.

Requires Improvement

Is the service caring?

Our findings

Staff spoke in a caring way about the people they supported, but this was not consistently reflected in their actions or language. For example, staff supporting a person with food and drink spoke over them, and did not address them respectfully to let them know what was happening. The same person had clothing protection placed around them at mealtimes without any communication from staff. Another person was focussed on an activity when staff approached them from behind and patted them on the shoulder. The person had not heard the staff member approach them, and flinched when they were touched unexpectedly. We also saw staff speak with and behave inappropriately with a third person. This was done in a way that contradicted the person's care plans, which asked staff to ensure appropriate boundaries were maintained with the person. However, we also saw staff support people in a kind and caring manner during our inspection. For example, staff supported one person, who appeared agitated, in a manner which was warm, sensitive and unobtrusive. The registered manager confirmed that staff should act in ways which demonstrated the values the provider outlined in their statement of purpose. This included providing care, "Within a warm and caring atmosphere." Staff did not consistently demonstrate they supported people with dignity and respect during our inspection.

People were not consistently supported to participate in designing or reviewing their care. Staff told us people were supported to express their views and wishes about their daily lives, but this was not always evidenced in care records. We saw some people participated in regular reviews of their care. However, for people who were less able to communicate verbally, there was no evidence how staff sought their views, wishes and aspirations. It was unclear how relatives participated in reviewing people's care. Daily records of people's care used language which was not person-centred and demonstrated a task-focused approach. For example, four people's daily records contained phrases like, "[Person] has had a positive shift," and, "A negative shift." People living at the service were not on a work shift: they were living at their home. Monthly reviews of people's care was focused on how staff felt care had been. People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. The provider could not demonstrate how people were involved in making decisions about their care. This meant there was a risk people's views, wishes and aspirations were not identified, and people were not supported to have care in ways that were meaningful to them.

People's confidential care records were not kept securely. They were accessible to people who lived at the service, staff, and any visitors. We raised this with the registered manager and they assured us action would be taken to keep information about people's care confidential. At the time of our inspection, confidential personal information was not kept securely, and people's right to confidentiality was breached.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs. Staff did not consistently provide support in accordance with people's assessed needs and support plans. One member of staff said, "You just see what works for you – they [people] have a care plan, but you just see what works." We saw staff supporting a person whose behaviour was escalating. The person communicated through their behaviour and staff confirmed our observation they were angry or distressed. However, staff did not recognise their techniques to support the person were not effective, which resulted in continued distress for the person. The registered manager had to intervene to ensure staff followed the guidance in the person's care plan.

Information about people's needs and preferences were not always recorded in care records. Staff told us they were able to contribute to updating people's care plans by sharing information with senior staff responsible for this. Staff said information they shared was not always recorded for all staff to be aware of. For example, one staff member described one person's preferences for specific cups, saying they would not drink from other cups. This staff member said it was important staff knew this to reduce the risk of the person regularly refusing drinks and becoming dehydrated. They told us and records confirmed this information was not documented. There was a risk staff did not have a shared understanding or consistent approach to providing care. This put people at risk of having care that was not tailored to meet their needs and preferences.

People were not supported to communicate effectively. Staff were not using communication support methods for people when care plans clearly identified this should happen. Staff told us about two people who needed their verbal communication enhanced by the use of Makaton. This is a language program using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech. Staff confirmed they did not use this, and said not all staff had received training. There was no evidence in staff records that training was provided in Makaton. We did not see staff communicating with the two people using Makaton to support speech during our inspection. One of the two people was also assessed as needing communication support using Picture Exchange Communication System (PECS). PECS is a communication technique for people with autism spectrum disorder and related developmental disabilities. Their care plan described when PECS should be used. Staff told us they did not use this. The registered manager was not aware that staff were not supporting people with their communication in accordance with their care plans, and assured us action would be taken to rectify this. People were unable to effectively communicate with staff about their needs, wishes and aspirations. This meant people's views about their care were not heard and acted on, and the provider did not ensure the person's autonomy and independence was enhanced.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no clear process in place for the provider to develop the service with people and their relatives. Staff and the registered manager could not provide evidence that issues or concerns raised by relatives or professionals were documented and dealt with appropriately. No formal complaints had been dealt with by

the service since our last inspection. Staff told us one relative regularly raised issues about the service, but there was no evidence to demonstrate what the issues were, or that the provider had responded in accordance with their complaints policy. There was no effective system in place for people or relatives to share their concerns and contribute to improving the service.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. One staff member said, "There appeared to be no managerial oversight." The registered manager confirmed the provider had asked them to provide support to another service, and this had taken them away from The Old Vicarage for periods of time over the last six months. They acknowledged this had contributed towards the issues we identified on our inspection. Social care professionals confirmed they had experienced the absence of a registered manager at times. During our inspection we identified shortfalls across all of the key questions we ask about services. This included failures in safe care practices and staff recruitment processes, insufficient staffing levels and staff training, planning and delivery of people's care, and failures to follow relevant legislation. Following our inspection visits, the provider confirmed with us that there were changes being made to the management of the service and within the provider, Creative Care (East Midlands) Limited.

Records relating to people's health and social care needs were not kept up to date and were not stored securely. Audits carried out by the provider had failed to identify records were not accurate or contemporaneous, and no action had been taken to rectify this.

Systems and processes in place did not identify learning from incidents and mitigate any future risks to people. This was important given the nature of the incidents and the complex needs of people using the service. The provider could not demonstrate training gave staff the skills and competence needed to support people safely and effectively. There was also no evidence that staff understanding or competency was assessed following training, apart from annual medicine administration competency checks. This meant people were at risk of being supported by staff who did not have the training or skills to meet their complex needs.

Quality assurance processes to ensure the living environment was safe for people were not completed accurately. For example, staff identified in a safety audit dated 14 February 2017 there was no carbon monoxide detector in The Stables. The audit recorded action was taken to remedy this on the same day. A visual inspection with the registered manager and deputy manager identified the monitor had not been activated. People had been placed at risk from safety equipment that was not working.

The processes in place to seek the views of people, relatives and staff, or use comments and concerns did not effectively drive improvement of the service. Staff told us, and records demonstrated concerns had been raised in staff meetings in relation to training and building maintenance. Staff told us there were opportunities to speak with senior management of Creative Care (East Midlands) Limited, but we did not see any evidence that issues raised in this way were uses to improve the quality of the service. There was no clear plan that identified what steps the provider was taking to resolve concerns identified by staff. Professionals expressed concern they were not consistently made aware of issues relating to the quality of people's care.

Staff understood their roles and responsibilities, but the provider was unable to demonstrate they were trained and supported to provide care that was in accordance with the provider's statement of purpose. A

statement of purpose is a legally required document that includes a standard set of information about a provider's service, including the provider's aims, objectives and values in providing the service. Staff did not consistently demonstrate that the training, skills and values the provider required were put into practice.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not appropriately notified the Care Quality Commission of all significant events as they are legally required to do. For example, there were two occasions where allegations of unsafe care or abuse had been brought to the provider's attention. The provider had liaised with the local authority, who had investigated. However, CQC did not receive notifications in relation to these incidents as required. This meant the provider was not informing CQC of significant events that occurred in the service which would have assisted us to monitor the quality of care. We spoke with the registered manager about this, and received assurance that notifications would be made in future.

These was a breach of Regulations 18 of the Care Quality Commission (Registration) Regulations 2009

Staff said if they had any concerns they would report them. Evidence from notifications we received demonstrated staff felt able to report concerns about the quality of care. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others.

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 18 Registration Regulations 2009 Notifications of other incidents 18 (1) (2) (e) The registered person did not notify the Commission of incidents of abuse or allegations of abuse in relation to people using the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (1) (b) and (c) People were not supported in a person-centred way with met their needs and reflected their preferences.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) Care and treatment was not being provided in a safe way for service users. 12 (2) (b) the provider was not doing all that was reasonably practicable to mitigate risks. 12 (2) (c) the provider did not ensure staff had the competence, skills and experience to provide care safely. 12 (2) (d) the provider did not ensure the premises were safe.

The enforcement action we took:

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

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 13 (1) People were not protected from abuse and improper treatment. 13 (4) (b) People were subject to control and restraint that was not properly assessed or reviewed, or a proportionate response.

The enforcement action we took:

Full information about CQC's regulatory response to these concerns found during inspection is added to

reports after any representations and appeals have been concluded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) Systems and processes were not operated effectively to ensure the service provided care that met the fundamental requirements. 17 (2) (a) Systems in place did not effectively assess, monitor and improve the quality of the service. 17 (2) (b) Systems in place did not assess, monitor and mitigate risks to the health, safety and welfare of people. 17 (2) (c) Records relating to people's care were not accurate, contemporaneous or stored securely. 17 (2) (e) Feedback from people, staff, relatives and relevant and other persons were not sought and used to evaluate the improve the quality of care. 17 (2) (f) There was no overall system in place to use quality monitoring evidence from a range of sources to evaluate and improve the service.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) There were insufficient numbers of staff to meet people's assessed needs. 18 (2) (a) Staff did not receive appropriate induction, training and support to enable them to meet people's assessed needs.

The enforcement action we took:

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