9 Grace Road Ltd

9 Grace Road Limited - 9 Grace Road

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

Overall summary

The Inspection took place on 16 and 17 July 2015 and was unannounced, which meant the provider did not know we were coming. We also returned on 6 and 19 August 2015, to ensure the changes that were introduced were effective and people were safe.

The service was last inspected on 2 July 2013 and at the time the service was meeting the regulations assessed during the inspection.

The service had a registered manager. 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. The registered provider was also the registered manager at this service.

Summary of findings

People were not protected from the risk of abuse and people had been abused by other people who used the service. Incidents were not identified as potential abuse; they were not reported or investigated by the appropriate professional bodies.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed to ensure the risk of harm was reduced to maintain people's safety.

People were given their prescribed medicines when they needed them, but staff were not aware of the potential side effects due to poorly completed risk assessments.

The legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not being followed. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so and the DoLS ensures that people are not unlawfully restricted.

People were prevented from leaving the home unlawfully.

People did not always receive medical support and interventions in a timely way to ensure their health and well-being were effectively managed.

Staff had a good knowledge of people's individual care needs. Risk assessments and care plans did not reflect the current support and care needs of people.

People's privacy and dignity were not upheld or respected.

People's care was not personalised and did not reflect their individual needs.

People were not involved in review of their care package or individual preferences.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. Poor care was not being identified and rectified by the provider.

We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC.

Summary of findings

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 at risk of harm and had been abused by other people who used the service.

Potential incidents of abuse had not been recognised or reported because the manager and staff did not know what to do if they suspected abuse.

Risks to people's health and safety were not managed and reviewed.

Staff were not always recruited safely.

Is the service effective?

Inadequate

The service was not effective.

Staff were unaware of the requirements of the MCA and DoLS, where people's liberty was being deprived.

Decisions had been made on behalf of people without appropriately determining if the person had capacity

Monitoring of medical interventions and health care services were not undertaken robustly to protect people from harm.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff we spoke with were knowledgeable about the individual needs of the people they cared for.

People's privacy and dignity was not upheld or respected.

People were not always responded to in a caring and compassionate way

Is the service responsive?

Inadequate

The service was not responsive.

People's healthcare was not properly assessed or planned for to be responsive to people's needs.

People did not receive the care and support they needed in an individualised way.

Changes to care and support needs were not recorded in a consistent manner.

People were not always supported to maintain and build on their independent living skills.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

The provider did not keep an overview of the home.

Effective systems were not in place to assess, monitor and improve the quality of care.

Poor care was not being identified and rectified by the provider.

9 Grace Road Limited - 9 Grace Road

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 16 and 17 July 2015, 6 August 2015 and 19 August 2015 and was unannounced.

The inspection teams consisted of two inspectors and an inspection manager.

Before our inspection we reviewed the information we held about the home and information from meetings held with the local authority commissioners and the police.

We had received two notifications from the provider since the last inspection. A notification is information about important events which the service is required to send us by law.

During the inspection we spent time observing the care being provided throughout the home. We observed people being supported at breakfast and during an afternoon session in the day care room. We spoke with the registered manager, a shift leader, a senior / cook, two care workers, and one agency worker.

We looked at records relating to all aspects of the service including care and staffing, as well as policies and procedures. We also looked in detail at three people's care records and the recruitment files of four care workers.

Inadequate

Is the service safe?

Our findings

People who used the service were not able to tell us if they felt safe. Some of the people who lived at the home had limited communication so we were unable to obtain direct verbal feedback about their experiences.

Staff knew how to recognise the signs of abuse and were able to tell us what the different types of abuse were. However staff did not know the safeguarding protocols and processes for reporting abuse as their understanding was they could only report direct to the home manager.

Although the staff we spoke with had understanding of types of abuse and how to report concerns, there was an incident in May 2015 that should have been reported immediately and the correct actions were not followed. This has now been reported to the local authority and the Care Quality Commission (CQC). At the time of our visit we have noted a number of other issues that should have been reported onto the local authority and CQC. The local authority has the lead role for investigating safeguarding incidents, and we have passed the information to them

The provider failed to make sure people who used the service were safe from the risk of harm. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's files did not reflect current and significant risks such as risks associated with known health conditions, or risks to others of sexualised behaviour. Staff who were working in the home had a limited understanding of what these risks meant for their practice and how to ensure people's safety. We found that the care staff had not been provided with any support to develop the skills needed to complete appropriate risk assessments around these types of behaviours and conditions. Staff told us that the manager wrote the care plans and told them when they had been reviewed so staff could read the information. Therefore care staff with the most up to date knowledge and information were included in the care plan and risk assessment review process which meant people's safety could not be maintained.

The provider told us that restraint was not used within the service. During the inspection we found that the use of restraint had been recorded in a number of people's daily reports. For example, one person had been locked within their room and had no access to their call bell should they require support. Staff did not understand the difference between lawful and unlawful restraint. This had not been recognised by the provider and no action had been taken to make sure that people were safe from the use of unlawful restraint. The CQC again reported these concerns directly to the safeguarding coordinator at the local authority.

The provider failed to make sure people who used the service were safe from the risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk assessments were reviewed with each care plan review. The tool used was a risk screening tool though there were no associated detailed risk assessments to identify control measures and ways to reduce the risks identified.

Risks to staff and people who used the service had not always been identified and assessed appropriately. There was an incident prior to our visit of a service user on service user assault. Following this the risk assessment for the perpetrator had been amended to include staff observations, but the risk assessment for the person who had been assaulted had not been altered and did not reflect the time they now spent isolated in their room. This meant that people's safety could not be ensured as staff did not understand how to appropriately protect people.

When we looked at other risk assessments there were further issues. For example we looked at the 'traffic light hospital information'. This is a document that is sent with a person if they were admitted to hospital to provide information on that person. The document we saw was the latest produced and dated May 2014. There was reference to the person having insulin controlled diabetes and a history of a hospital acquired infection, yet neither of these conditions was entered on the risk assessment. There was a further issue where another person had a different hospital acquired infection, which was not reflected in their risk assessment. That meant staff that did not have a detailed knowledge of people could endanger them and others through inappropriate care.

The provider had failed to make sure that risk had been thoroughly assessed to protect people from harm and ensure their safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Individual personal fire evacuation plans had not been completed. Each person should have an individual assessment to identify their own needs in case of an emergency and how to support them to ensure that they are safe. We also asked the provider for the fire safety checks but he could not produce the folder. We referred these issues to the appropriate fire authority for them to follow up.

There were five staff members on shift in the morning and afternoon, including one person who was designated as the cook for each shift, and two waking night staff overnight. One person was receiving one to one support during the daytime and an additional member of staff was being used to provide this. Staff told us that agency staff were used regularly. The agency staff said that they worked at the home regularly and had received an induction. The provider told us that there were enough staff to provide the care and support and meet people's needs. We observed the staff group who provided a safe environment for people; however that was where people were secluded in bedrooms, and not always at liberty to freely walk around the home.

The provider did not have a consistent recruitment process in place to ensure people's safety. Recently employed people had completed a check with the Disclosure and Barring Service (DBS) before starting work. We looked at four staff recruitment files. Of those two people had been employed as care staff since 2007. Both had completed a Criminal Record Bureau (CRB) check prior to commencing work, which was the check prior to the DBS being introduced. When we spoke with the staff they said that there had not been any checks in the intervening period. That meant the provider did not have a system in place to ensure that staff remained safe to work with people following the initial pre–employment checks and no arrangements were in place for updating these checks once staff were in post.

When we looked at other staff files, we noted there were inconsistencies with the recruitment process. In the first file the person had not declared their whereabouts or employment since they completed a college course in 2013. There were no notes about where the person had been between completing the college course and applying for the care assistant post at 9 Grace Road during March 2015. This had not been followed up at interview. There was a verbal reference from the manager where the employee had completed work experience from the college course. There were no copies of any written references in the file.

Medicines were handled appropriately and kept safely. All medicines were stored in locked cupboard in a specific room. We found that people's medicines had been reviewed by their doctors and any changes to medicines had been actioned.

Signatures of staff who administered medicines were at the front of the medicines administration record (MAR) folder so responsibility for the administration of medicines could be tracked. People's photographs were at the front of their MAR chart so that they could be identified as the right person before being given their medicines.

When we looked where people were prescribed 'as required' or PRN medicines, we did not see any protocols in place. These are used to regulate the use of these as required medicines, and specify when and under what circumstances these should be given. Some of these medicines were sedatives used to manage behaviour that challenged. There were no prompts, such as deflection techniques to avoid behaviour escalating, and no instruction on how often to administer the medicine before alerting the GP or calling for back up services. That meant that people were placed at risk of being given these medicines more regularly than required.

We saw where two people had been administered PRN medicines before visits to health professionals. There was no signed authority to authorise this, which meant that the person may be placed at risk from receiving more medication than prescribed.

We saw that other than the medication administration record (MAR chart), there was a laminated A4 sheet detailing what medicines people were prescribed. In one file the laminated sheet was a different dose to the MAR chart. Neither the staff administering the medicine, nor the provider was aware of this variance. That meant the person's records were not up to date, and the person was in danger of not receiving enough or too much of the prescribed medicine.

The medicine in question had some serious side effects and some circumstances produced a severe reaction. There was no documentary evidence in the MAR chart, laminated document or care plan about this. That meant

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Is the service safe?

the person was being placed in danger from lack of staff information. All three of the eight laminated sheets we reviewed were out of date, and we made the provider aware of this. This meant people were placed at risk from incorrect medicines being administered due to inconsistent medical information.

We were unable to locate a policy and procedure for medicines administration. We asked the provider for a copy but he was unable to locate this. There was no document in place to train staff, and ensure their administration procedures were consistent.

When we looked at the care files they contained a number of historical documents. A number of people had information of long standing hospital acquired infections. Staff were aware that some people had these types of infection, but there was no information that was specific to the individual about how to protect themselves and others. There were no control measures in place about the use of personal protective equipment (PPE) and staff were not aware of any protection measures they should take when asked.

We did see some information in the 'staff file' about hospital acquired infections. This file was locked in the under stairs cupboard, and staff explained this included general information about people in the home. We found the information was out of date, and was not cross referenced or signposted so staff could identify where the latest information on hospital acquired infections could be found. This means that people's safety was not consistently ensured through up to date infection control practices.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff told us that they received regular supervision every two to three months and that they had completed a range of training courses. The majority of training that staff undertook was through the completion of distance learning booklets on different subjects that they needed knowledge of as part of their role. Some staff had undertaken external courses that were provided by the NHS and other providers. New staff had a period of training and induction.

However we found the staff training records showed that majority of staff had not had updated safeguarding training. Of the 20 staff named on the training record only three had been on courses since January 2014, as referenced with in the 'safe' key question where we identified issues with safeguarding. Of those three, two were the general manager and care manager. That meant care staff were not trained to recognise where people were at risk from staff being unable to recognise and protect people placed in their care.

Care staff told us they were aware of the Mental Capacity Act (MCA) 2005. Two staff told us they had completed training in this area. The MCA is legislation used to protect people who might not be able to make informed choices on their own about the care and support they receive. Staff did not understand the requirements of the Mental Capacity Act 2005 and had not fully introduced either the principles or the appropriate documentation into the home, for example people who were restricted in moving to parts of the home or movement within floors of the home due to door locks. We found no reference in care records about people's capacity. Staff were not able to tell us if any mental capacity assessments had been carried out. Decisions had been made on behalf of people without appropriately determining if the person had capacity, any assessments taking place or a best interest decision being made involving the people who know the person. This meant that the provider had failed to adhere to the five principles of the Mental Capacity Act 2005.

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

People were at risk of care that was not safe, effective or that met their needs. One person required a medical condition to be constantly monitored. We saw from letters that the person had a visit from a health professional and they instructed how the person's health should be monitored and recorded. The monitoring that was undertaken was not in a dedicated document and was not undertaken regularly. That meant that staff could not interrogate the records and see any decline of their health over a period of time.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were not able to tell us about their food choices. Some of the people who lived at the home had limited communication so we were unable to obtain direct verbal feedback about their experiences. We did however look at the daily records which detailed what food choices people were offered. We found one person was also restricted in what they were able to eat or drink. People had no open access to the kitchen and we were told that they were offered drinks, at regular intervals during the day.

We were made aware of a person with a degenerative health condition. Following intervention by a health worker staff were required to monitor this by completing detailed records of the person's nutritional intake, and a monitoring record of their weight. The staff had commenced a record, but this was not maintained effectively, and so did not reveal the persons weight loss over an extended period of time.

This person became seriously ill and was admitted to hospital. Had the records been completed appropriately, the person may not have had required an emergency admission, as continued monitoring of the persons condition may have alerted the staff to engage further healthcare assistance sooner.

Staff could tell us how some people who use the service could make limited choices about clothes they wear or food they ate. They were able to identify this through using pictures for people to make a choice of food from, people's body language and behaviours. This knowledge was developed from working with the individuals and staff used different approaches. Information that the staff told us about how to support someone to make a decision was not recorded within care plans. Staff told us that some people were not able to make their choices known so they used information that was known to decide what to give that person to eat, or what to offer them to wear.

Inadequate

Is the service effective?

All people using the service were only allowed to leave the home if they were accompanied by staff. One person smokes and the staff give them cigarettes at certain points throughout the day. There were no mental capacity assessments in place for the people using the service and no best interest decisions had been made on their behalf, to cover these restrictions.

People who had restrictions placed on their freedom and liberty had not been referred to the DoLS team for authorisation. This meant that people using the service may have been unlawfully deprived of their liberty.

Staff did not always take action or carry out appropriate recording when there were concerns about people's well-being. A health professional advised that staff should record the length of a person's epileptic seizure. This information is important as the person requires rescue medication after a specific period of time. It also helped to monitor the frequency and length of seizures so that a consultant can see how the person is responding to any medication they are taking.

There was limited information relating to people's health needs and associated risks with diagnosed conditions. For example one person had a blood disorder which could have resulted in a hospital admission following the slightest injury or bruise. This was mentioned in the person centred plan, but there was no signposting in the main care plan. Another person had another disorder which required continual monitoring of their diet, eye tests and specialist chiropody. Again this was mentioned in one file, but not signposted for staff in other files. This means that due to this limited access to information staff members that did not have historical knowledge of peoples conditions may not have been fully aware of the risks that come from people's enduring health needs.

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Requires improvement

Is the service caring?

Our findings

We saw some examples of staff being very kind and caring to people who used the service and instances where staff sat with people and supported them with a meal, talking to people and involving people in activities.

We observed breakfast on the first day of our inspection and saw 10 people in the room together sitting at three tables. Three staff were assisting with breakfast, one was supporting a person to eat and sat with them throughout the meal. Another member of staff was bringing people their breakfast and the third was stood talking to everyone. One person was waiting for food, when it was brought to them the member of staff started to assist them to eat and then walked away. The person stopped eating until another member of staff came to support them. This showed that people were not always responded to in a caring and compassionate way.

We noted there were no drinks available when people were eating breakfast. One person who was looking for a drink, was wandering around the home trying to access the kitchen to get a drink. Staff members kept asking the person to wait for a drink and redirected them back to the breakfast room but did not provide a drink. This showed that people were not responded to appropriately.

We observed the staff group throughout the breakfast period. Though there were five staff on duty, they did not supervise the group appropriately to ensure people enjoyed their meal and were given the appropriate levels of assistance when it was required.

We observed a period where people were engaged in a game of bingo and other activities. We found that people engaged in the activities at first and enjoyed them. However, over a period of time, people lost interest in bingo and the member of staff was not able to encourage them to participate further as a group. We noted that the member of staff spoke with each person, but some people needed more one to one support to engage them in activities.

We found within care plans that people were not always involved in the planning or review of their own care. Staff told us that the only people that compiled and reviewed care plans were the general manager and the care manager. We could not confirm this as a number of people who lived at the home had limited communication.

Bedrooms that we saw had been individualised and had personal items in them.

Staff told us that there were communal sponges that were used once for washing people. These were then washed but people did not have their own washing items. We confirmed this with other staff and through checking in the laundry; we were told that it depended upon the key worker and some people did have individual sponges. Staff also told us that two different coloured flannels were used; one for the face and one for other areas but these were also shared between people and washed after each use. This showed a lack of personalisation and did not respect people's individual dignity.

We discussed this with the provider, who advised that he would throw the items away immediately and make sure each person had their own washing equipment.

The registered manager told us that a number of people did not have an appropriate family member or friend to represent their views. People were not supported to access to an advocate to represent their views and make sure that what they wanted was happening. An Advocate is a trained professional supporter, to enable and empower people to speak up, or represent their views.

Inadequate

Is the service responsive?

Our findings

People's healthcare was not properly assessed and planned for as there was a lack of review systems in place that recognised people's overall health and care needs. Staff told us that information was not always clear in care plans. We were told that the care plans did not meet the needs of the people who used the service. Information about people's health needs were difficult to find and we needed to look at several records to find the information needed. Staff told us how they supported people, but the information was obtained from working with the people, and additional information from staff who worked with the person over a period of time.

One person was identified as having episodes of 'challenging behaviour' however there was no information in current records about what might trigger this, or any advice on how staff should respond if this occurred. Three members of staff gave different interpretations on how they would support this person if they were presented with challenging behaviour. They said that that the information was not clear in the care plans how to support the person. They did say they knew how to support the person as other staff had told them, or shown them what to do.

In 2012 the Outreach Team from Leicester Partnership NHS Trust worked with this person and developed a step by step process for the most effective way to manage their behaviour. A brief extract from this was recorded in the care plan review in 2012, but did not give all the information to staff. This full information was only available if staff knew to refer to the full response to the review in 2012. Without the specific guidance that had been developed the staff may have been using different ways to support the person. This means that staff were not consistent or responsive in their approach, which in itself may generate further behavioural issues for this person.

There were a variety of documents in place including care plan reviews, risk screening tools, person centred care plans, health action plans and daily diaries.

We spoke with four care staff, who gave differing information as to which document from a number of documents was meant to be the care plan. One staff member said it was the person centred care plans, two said that it was the care plan reviews and another staff member said it was a 'care plan' but could not identify exactly which document this was. That meant the information was not easily accessible and staff were unable to see how to support people in a way which was responsive to their needs.

Each person had a health action plan (HAP) which had limited information. When we looked closely at the plans they were out of date even though it was recorded that these had been reviewed in February 2015. For example one person's health had started to deteriorate around a year ago. The person's needs had changed with their communication and mobility. These changes were not reflected in the health action plan that was reviewed in February 2015.

Where people were at risk of developing pressure ulcers there was a lack of management to reduce the risk. A nurse recommended that one person needed to be turned every two hours to reduce the risks of pressure ulcers. This was recorded in the daily diary but there was no care plan in place to guide staff. Turns were recorded in the daily diary and the notes made by staff indicated that the person was not turned every two hours and overnight; in the majority of cases no turns were recorded. We found there was no dedicated record for this activity. Had that been in place the staff would have found it easier to record the actions and review the document to ensure the turns were provided as prescribed by the health professional.

We also found that documentation that could help staff record specific details such as areas of bruising or the size and depth of pressure areas were not in place. That meant there was potential for information to be recorded inaccurately and made review of such injuries more difficult.

Each person had a person centred care plan (PCP) that was written in an easy read format and had some information about people's likes and dislikes. An easy read format has pictures and symbols as well as brief sentences. This could enable some people to follow some forms and documents if they are produced in this manner.

Some of the information in the PCP was quite limited and was out of date even though it had been recorded that the plans had been reviewed in 2015. For example one plan indicated a person liked 'movies'. There was no explanation what type of movies, though in this person's day centre records, it was recorded they spent a lot of time watching movies.

Inadequate

Is the service responsive?

The care plan reviews, person centred care plans and health action plans only recorded people's needs in a very basic way including how people communicate. There was very limited information about people's wishes, needs, routines and preferences. There was no information about capacity, how people make choices, if people were subject to any legal constraints such as deprivations of liberty (DoLS) or who managed people's money. It was not clear from the documents how staff supported people with their daily lives.

Each person had an individual file that contained letters from health professionals, all care plan reviews and other information. Within this file there was information about people's history and why they had moved to the home but this was not easily identified. That meant newer staff would need to rely on information from other staff to ensure people were cared for using the most up to date information.

Actions are included within the care plan reviews but these are not recorded for staff to plan how to achieve these and report on progress.

One member of staff said that the plans were 'basic', and they were informed of care plan reviews through an entry in the communication book. Another member of staff said that new staff may struggle to understand the care plans, which they meant due to the number of different documents being used, and the abbreviated system of care plan reviews. That was where the full care plan was presented to staff in a condensed form, but did not highlight any changes. That meant newly employed or agency staff would find it difficult to comprehend the care plans, until they had a depth of knowledge about the people in the home.

Updated information from health appointments and data that was requested to be recorded was stored within the daily diaries. This means that staff did not have an efficient means to summarise or review the information when it was needed, and it could be missed as it was not stored in a dedicated record. Visiting professionals raised concerns with us about not being able to find information relating to individuals in a clear and accessible way.

People were not always supported to maintain and build on their independent living skills. Day centre activities were planned in advance and each person had a timetable, although a lot of activities were the same for each person. The activities focused on pampering, watching movies, going out on trips, swimming, puzzles and arts and crafts. People were not given the opportunity to be involved in cleaning their home or bedroom, cooking, washing their clothes or planning meals. Although people may not be able to complete a task alone with support they can be involved in parts of tasks and this helps to promote independent living skills and confidence.

Visiting professionals also raised concerns with us about the lack of social activity for some people. One person was assessed as having one to one support once a month to go out and be offered day trips. The last time they went out was 2 February 2015; there is no record of day trips in the person's notes.

There was a complaints procedure for people to follow in the foyer of the home near the door. This was not in an accessible format. The document had not been updated for a period of time as it referred people to the Commission for Social Care Inspection (CSCI), which was the organisation responsible for regulation before CQC, which took over in 2009. CQC do not handle complaints and people should be referred to the Local Authority or Local Government Ombudsmen if they are not happy with actions the provider has taken in relation to complaints.

We asked the provider for the record of complaints. He told us there were none, but he could not find the records to refer to.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post, who was also the provider. He had decided to step back from managing the home and appointed a general manager and care manager to run the home on a day to day basis. Both of these people were registered managers at another locations owned by the provider.

Checks on moving and handling equipment were not made to ensure they were safe and kept in good working order. For example we looked at the moving and handling equipment and there were a number of hoists in use which required a Lifting Operations and Lifting Equipment Regulation 1998 (LOLER) check. We checked four of the hoists. One was due to be checked in October 2014 but this had not been recorded as being completed, a further two did not have records of when checks have been carried out, and one was not due to be tested until November 2015. The provider advised us that all the testing had been carried out in March 2015 but was not able to find paperwork that recorded this.

Effective systems were not in place to assess and monitor the quality of care. For example, no audit systems were in place to assess and monitor the quality of the information contained in people's care or health records to ensure information was current and appropriate in order to meet people's needs. We saw inconsistent recording where information in the 'traffic light hospital information' did not match the risk assessment (see 'Is the service safe?' for details). That meant people were at risk of harm due to the lack of effective monitoring of associated care and health documents.

We asked the provider for the records of safety tests. The periodic test of gas appliances and fire extinguishers were available and in date. However the tests of the fire alarm system, emergency lighting and water safety tests could not be found. The provider stated he did not regularly look at these and had them out for a local authority check, but now could not find them. We forwarded our concerns to the local fire authority to follow up missing fire and evacuation records.

Care plans, PCP's, HAP's and risk assessments lacked clear, concise information to enable staff to care for people. Reviews of people's care was regularly undertaken, but did not cover all the documents, include review of all the information or updates to ensure the care that people were receiving reflected their inclusive needs and all the documents included matching information.

The provider had not raised safeguarding referrals with the local authority when there had been incidents of suspected abuse and did not recognise the need to so. Investigations were not carried out to reduce the risks to people and lessons were not being learned to ensure people were protected from further harm.

This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Team meetings were arranged and details of the dates were available on posters in two locations in the home. We asked for minutes of these but the provider could not produce the records.

Staff were aware of the whistleblowing procedure and all staff spoken with said that they felt they could raise concerns with either of the two day to day managers or the provider when they saw him. There was whistleblowing information available for staff in a communal area.

The provider stated to us that the policies and procedures had been 'revised but not updated'. When I asked how he knew this he indicated the care manager had told him, but he had not looked at these himself. We asked the provider about the inclusion of DoLS, the MCA best interests meetings in the policies and procedures, but he did not answer.

We asked the provider to access some quality assurance information on the computer. He attempted to do so, but could not access the computer as he did not have the password necessary. We then asked the provider who undertook the quality assurance checks in the home, he replied "I don't know."

We were able to contact the general manager, and we asked about quality assurance and how this was undertaken. He told us most changes were done at staff meetings, where any changes were shared with the staff. He also prompted us to look at the quality assurance file. The provider produced the file, but there were no reviews of documents, copies of any tests or any audits or monitoring documents. There were however a number of updated forms in the file, which were revised versions of part of the

Inadequate

Is the service well-led?

recruitment and staff supervision sessions. That meant there was no consistency in the monitoring or review of practices in the home, which would have allowed the provider an overview of how the home ran.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 **Service users were not safeguarded from abuse and improper treatment.** **Regulation 13 (4)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **The provider did not ensure reportable incidents, accidents were sent to CQC. Regulation 20 (2)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not established and operated effectively to ensure compliance with the requirements Regulation 17 (1) (2)